

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000	Preparation or execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed, as required by the provision of federal and state law.	
F 364 SS-E	<p>483.36(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to prepare food which was at the proper temperature at point of service as evidenced by milk served at fifty-eight (58) degrees Farenheit and a cold dessert pudding served at sixty-eight (68) degrees Farenheit.</p> <p>The findings include: Observation of temperatures measured on 01/25/11 at 12:45 PM for point of service revealed milk was served at fifty-eight (58) degrees Farenheit and the dessert pudding was served at sixty-five (65) degrees Farenheit. Interview with the Dietary Manager on 01/25/11 at 12:50 PM revealed the milk and the pudding were too warm. Review of the facility's policy titled "Food Temperatures," not dated, revealed milk and</p>	F 364	<p>RECEIVED MAR 4 - 2011</p> <p>BY: _____</p> <p>F 364</p> <p>Dietary Services</p> <p>Food that is palatable, attractive and at the proper temperature</p> <p>Milk will be placed in a bowl of ice during tray line to maintain temp.</p> <p>The temp logs have been revised to include testing of milk and all foods being served at the beginning of tray service and midway through tray service to assure proper temperatures are maintained. (attachment F 364 #1)</p> <p>Dietary staff was inserviced on the new temperature log, appropriate holding temperatures and the method of storing milk on the tray line on 2/18/2011</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Donna Fudge</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2-18-11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER

BAPTIST CONVALESCENT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

120 MAIN STREET
NEWPORT, KY 41071

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F 364 F 367 88=D	<p>Continued From page 1 puddings were considered cold foods and should be served at forty (40) to fifty (50) degrees Farenheit.</p> <p>483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the residents received the appropriate form and/or appropriate nutritive content as prescribed by the physician for one (1) of twenty-four (24) sampled residents (Resident #8). Observation, on 01/25/11 at supper; and, on 01/26/11 at lunch, revealed the resident received a No Added Salt Regular Ground Diet. However, the resident was prescribed a Controlled Carbohydrate Mechanical Soft Diet.</p> <p>The findings include:</p> <p>Review of Resident #8's medical record revealed diagnoses which included Senile Dementia, and Diabetes Mellitus. Review of the Annual Minimum Data Set Assessment dated 11/16/10 revealed the resident was oriented and required extensive assistance with most Activities of Daily Living (ADL's).</p> <p>Review of the Care Area Assessment (CAA) dated 11/16/10 revealed the facility assessed the resident as requiring a mechanical soft consistency diet for chewing and swallowing ease and a CCHO (complex carbohydrate) restriction</p>	F 364 F 367	<p>The Dietary Tech will monitor completion of these logs while doing the tray service audit three times a week. Audit results will be reported to the QA coordinator weekly and reviewed at the monthly Quality Assurance committee meeting</p> <p>F 367</p> <p>Therapeutic Diets must be prescribed by the physician</p> <p>The selective menus have been temporarily suspended for residents who take meals on the units.</p> <p>Resident #8's correct diet order was entered in the computer diet ticket program on 1/27/11</p> <p>All residents charts were audited by end of day on 1/27 and checked against the computer ticket program</p> <p>A second audit was completed by 2/18/11 by the dietary tech to compare most recent diet order to diet ticket. (see attachment 367 #1)</p>	2/19/2011

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F 367	<p>Continued From page 2 related to Diabetes Mellitus Type II.</p> <p>Review of the Plan of Care, dated 12/28/09, revealed the resident had the potential for hypo/hyperglycemia related to Diabetes Mellitus with an intervention to serve diet as ordered.</p> <p>Review of the Physician's Orders dated 01/11 revealed Orders for a Mechanical Soft Controlled Carbohydrate Diet.</p> <p>Observation on 01/25/11 at 6:10 PM revealed the resident was eating supper and feeding self in bed. Review of the meal ticket on the tray revealed No Added Salt Regular Ground Diet.</p> <p>Further observation on 01/26/11 at 12:00 PM revealed the resident was in a wheelchair in the hallway feeding self lunch. Review of the meal tray revealed the resident received spaghetti, broccoli, pudding, yogurt and applesauce. Review of the meal ticket revealed No Added Salt Regular Ground Diet.</p> <p>Interview on 01/26/11 at 12:50 PM with Licensed Practical Nurse (LPN) #9 revealed the resident had received a No Added Salt Regular Ground Diet per the meal ticket. She reviewed the Physician's Orders and stated the Orders were for a Mechanical Soft Controlled Carbohydrate Diet. Further interview revealed staff were to check the tray ticket against the diet received when passing meal trays.</p> <p>Interview on 01/26/11 at 1:00 PM with the Dietetic Tech revealed the resident received the wrong diet. She stated, when the Physician writes an order for a diet, the nurse completed an Interdepartmental Communication Form. She</p>	F 367	<p>The dietary tech will attend the morning QA meetings where all new orders from the previous day (or weekend if Monday) are reviewed. If a diet order has changed, the dietary tech will then check the ticket information to assure it has been updated</p> <p>End of line tray audits will be done 3 times a week by the dietary tech or designee at various meals to assure foods served are appropriate for diets ordered. Inappropriate trays will be returned immediately for correction. The results of these audits will be reviewed with the QA coordinator weekly and at the March 8th QA meeting where a determination of the frequency of ongoing audits will be made.</p> <p>Whole house diet order audit compared to ticket information will occur monthly x 2 (March and April) to determine the effectiveness of the new order/order change process described. Revisions to the order change process and frequency of audits will be determined by the QA committee based on audit results.</p>	2/19/2011

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F 367	Continued From page 3 stated the form had three (3) parts; the yellow copy was sent to her, and the white copy was sent to the Dietary Manager for the diet clerk to enter into the computer. Interview on 01/27/11 at 2:00 PM with the diet clerk revealed she received the Interdepartmental Communication Forms for diets and entered the information in the computer. She then filed the forms in the file cabinet. Continued interview revealed the Dietician also entered diets in the computer. Review of the dietary file with the Dietetic Tech on 01/27/11 at 5:00 PM revealed there was no form in the file for the No Added Salt Regular Ground Diet. Interview on 01/27/11 at 2:30 PM with the Dietician revealed she wrote Physician's Orders for diets and nursing completed the Interdepartmental Forms to be sent to dietary. Further interview revealed nursing may have written the wrong diet on the Form or it could have been entered into the computer wrong by dietary. She stated the resident had no problems with his/her blood sugar per the laboratory data. Interview on 01/27/11 at 5:30 PM with the Administrator revealed there was a change in dietary with the "new choice program" where residents were allowed to select their meal choices each day and all resident tray tickets had been changed recently due to the process. She stated the facility was still working out the problems with the new system and more than likely the diet had been entered wrong in the computer.	F 367		
F 371 SS=F	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 4</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions as evidenced by; serving utensils being used to plate multiple food items, outdated food items stored in the refrigerator, improper glove changing and hand sanitation method, improper wearing of hairnets and dust covered vents located around the stove hood and three (3) compartment sink/food preparation area and above the area where tray carts were stored.</p> <p>The findings include:</p> <p>Observation, during the initial tour on 01/25/11 at 12:35 PM, revealed a plastic storage container with a plastic bag containing liquid egg which had been torn open sitting in the container on the top shelf of a food storage rack in the walk-in refrigerator. The container was noted to be uncovered with no date.</p> <p>Interview with the Dietary Manager (DM) on 01/25/11 at 12:35 PM revealed the egg should not have been stored in this manner, and should</p>	F 371	<p>F 371 483.35 (i) food procure, store/prepare/serve – sanitary</p> <p>The chopped ham, liquid eggs, and tomatoes were discarded. The dietary staff was reeducated on 1/25/11 and 1/26/11 by Linda Stamper, food service director, on labeling and dating items before placing them in the walk in. They were also reeducated on left over items not being left in refrigerator for more than 48 hours before being discarded. A mandatory formal inservice for all dietary employees was done on 2/17/11 by Paula Kuhnen, RN, Staff Development Coordinator. (See attached policy, attachment F 371 #1.)</p> <p>Compliance will be monitored three times weekly on the "refrigerator foods" audit (attachment F371 #2) conducted by the Dietary Tech. The Dietary Tech is to immediately assure corrections are made as infractions are identified. The audit will be reported weekly to the QA coordinator, who will supervise the completion of the corrections and report each month at the monthly Quarterly Assurance meeting as part of the QA process. Revisions to the frequency of the refrigerator foods audit will be determined by the QA committee based on audit results</p>	

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F 371	<p>Continued From page 5 have been covered and dated.</p> <p>Observation on 01/26/11 at 12:45 PM revealed seven (7) vents which were noted to have a dusty build up on them with a dust like substance blowing from three (3) of them.</p> <p>Interview with Dietary Aide #4 on 01/25/11 at 6:20 PM revealed he was given the task to clean the vents and did not remember the last time they had been cleaned. Further interview revealed he was unable to clean the vents alone because it took at least two (2) people to take them down, and they could not be cleaned during the day because the dirt and dust could blow into the residents' food.</p> <p>Observation on 01/25/11 at 12:55 PM revealed chopped pieces of ham which were not dated and stored in the first refrigerator from the door leading into the kitchen. Also noted in the same refrigerator was deli meat and chopped tomatoes both stored in separate half-sized hotel pans dated 01/16/11 and sliced tomatoes stored in a quarter size hotel pan dated 01/16/11.</p> <p>Interview with Dietary Aide #3 on 01/25/11 at 1:00 PM revealed the items should not be refrigerated for more than forty-eight (48) hours before being thrown away.</p> <p>Observation on 01/25/11 at 4:15 PM revealed Dietary Aide #5 answered the telephone and did not change gloves or wash his/her hands before returning to trayline.</p> <p>Interview with Dietary Aide #5 on 01/25/11 at 4:20 PM revealed he/she should have washed his/her hands prior to returning to wrap sandwiches after</p>	F 371	<p>The lead dining room server will be assigned responsibility to monitor reach-in refrigerator each morning and throughout the day for proper dating and labeling. The cook and cook's helper will be responsible for monitoring the walk-in refrigerator and freezer each morning and throughout the day for proper dating and labeling. This monitoring is to assure food is stored appropriately to prevent use of potentially outdated food.</p> <p>Vents in the kitchen were cleaned, removing any dust that had accumulated, on the evening of 1/25/11. Dietary Aid #4 was reminded and reeducated of his assigned cleaning schedule. He was also shown how to clean the vents without having them removed from the ceiling. A cleaning schedule will be posted with duties and signature lines to be signed off when duties are completed. (attachment F 371 #3) The vents will be cleaned once a week after the evening meal is completed.</p>		

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F 371	<p>Continued From page 6 answering the telephone.</p> <p>Observation on 01/25/11 at 4:40 PM and throughout the evening meal service revealed the DM used the same tongs to serve the potato wedges and the chicken with gravy twenty-five (25) times.</p> <p>Observation on 01/25/11 at 4:45 PM revealed the DM used the same ladle for the chicken and vegetable soups.</p> <p>Interview with the DM on 01/26/11 at 12:10 PM revealed the desserts were sent on a closed cart. She further indicated this was the way it had always been done.</p> <p>Observation on 01/25/11 at 4:30 PM revealed Dietary Aide #6 opened the refrigerator door to obtain salad for the resident trayline and was not observed to wash her hands or change gloves before returning to the trayline.</p> <p>Interview on 01/25/11 at 6:15 PM with Dietary Aide #6 revealed she should have washed her hands before returning to trayline after opening the refrigerator. She further indicated they were in a hurry.</p> <p>Observation on 01/25/11 at 6:15 PM revealed the DM had placed tongs used to serve the chicken with gravy and potato wedges in the pureed omelet. It was noted she then used those tongs to plate potato wedges.</p> <p>Observation on 01/25/11 at 5:45 PM revealed the trayline had ran out of pureed chicken, and the DM placed some regular chicken on a plate to be taken to be pureed. The DM used the scoop</p>	F 371	<p>The Dietary Manager (acting) will be responsible for reviewing the cleaning checklist each day to assure cleaning tasks are completed as assigned. The Dietary Technician will monitor the cleanliness of the kitchen, including the vents, three times a week and note results on the Sanitation Audit checklist. The Dietary Manager (acting) will be responsible for implementing any needed corrections for infractions found during audit. The audits will be provided to the QA Coordinator weekly and reported at the monthly Quality Assurance meeting as part of the QA process.</p> <p>The administrator will do a walk through of the kitchen at least three times a week to observe kitchen cleanliness.</p> <p>All dietary staff have been re-educated related to hand washing and glove use and the need to remove gloves and wash hands between serving food and handling other items while serving meals. This includes touching refrigerator door handles, telephones, items dropped on floor, eyeglasses or hair. An informal inservice was conducted by the Administrator, Donna Prodge, with the dining room staff on 2/15/11. A mandatory formal inservice for all dietary staff,</p>		

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F 371	<p>Continued From page 7</p> <p>which had initially been used to dip the pureed omelet to dip out gravy and pour on the plate with the chicken. It was noted the scoop was returned to the pureed omelet after being used to scoop out gravy from the regular chicken pan.</p> <p>Observation on 01/25/11 at 6:00 PM revealed the DM used the same ladle for chicken noodle soup and the omelet.</p> <p>Interview with the DM on 01/25/11 at 6:10 PM revealed normally each food served on resident trayline has its own serving utensil secondary to the possibility of cross contamination.</p> <p>Observation on 01/25/11 at 6:05 PM revealed five (5) plate warmers stored with a white wax-like substance on them which was cracking and flaking off, two (2) of which were sent down the trayline to residents.</p> <p>Interview on 01/25/11 at 6:05 PM with the DM and Dietary Aide #4 revealed they did not know what the substance was. Further interview revealed it could possibly be some of the warmers had busted and the substance inside had leaked onto the outside of the warmers.</p> <p>Observation on 01/26/11 at 11:25 AM revealed Dietary Aide #2's hairnet did not properly cover her hair leaving the front portion exposed while plating food to be served to residents.</p> <p>Observation on 01/26/11 at 12:25 PM during the lunch time meal service revealed Dietary Aide #2 pushed her glasses up and did not change gloves or wash hands while working on trayline. On 01/26/11, at 12:26 PM Dietary Aide #2 was noted to again push her glasses up and continue to</p>	F 371	<p>dining room and kitchen, was completed by the Staff Development Coordinator, Paula Kuhnen on 2/17/11. (attachment F 371 #4) Return demonstration for washing hands and donning gloves was performed by all dietary department staff.</p> <p>The process will be monitored by the Dietary Manager (acting) with the assistance of the Dietary Technician three times per week, using a Tray Service sanitation checklist (attachment F371 #5). This includes monitoring food handling during tray pass to assure sanitary conditions are followed so that no resident is affected by lack of this process, resulting in potential contamination of food. This monitoring will be reported to the QA coordinator weekly and to the Quality Assurance committee at the monthly meeting March 8th. The frequency of further monitoring will be determined by the QA committee based on evaluation of completed audits</p>	
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F 371	<p>Continued From page 8</p> <p>work on the trayline without changing gloves or washing her hands.</p> <p>Observation on 01/26/11 at 12:36 PM revealed Dietary Aide #2 dropped a pot holder on the floor, plucked it up, and changed her gloves. She did not wash her hands before donning new gloves for the resident trayline.</p> <p>Observation on 01/26/11 at 12:37 PM revealed Dietary Aide #2 knocked over a container of parsley onto the floor. She was observed to pick the parsley up off of the floor and change gloves. She did not wash her hands before donning gloves and returning to resident trayline.</p> <p>Interview on 01/26/11 at 12:55 PM with Dietary Aide #2, revealed her hairnet should have covered her hair better, and she should have washed her hands and changed her gloves before returning to the trayline, after touching her glasses and picking items up off of the floor.</p>	F 371		2/20/2011
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective</p>	F 441	<p>F441 438.65 Infection control, prevent, spread, linens</p> <p>All nursing staff were re-educated regarding proper hand washing after each direct contact with a resident. An informal inservice was conducted by the unit coordinators 1/27/11 - 1/30/11.</p>	

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F 441	<p>Continued From page 9 actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain an Infection Control Program to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection.</p> <p>The findings include: Observation of the supper meal on 01/25/11 at 5:55 PM revealed Kentucky Medication Aide (KMA) #1 was sitting between Unsampled Resident A and Unsampled Resident B and</p>	F 441	<p>A formal inservice regarding proper handwashing and meal service was conducted by Staff Development Coordinator, Paula Kuhnen on 2/17/11 (attachment F411 #1).</p> <p>Each unit coordinator will conduct a meal service audit 3 times per week at various meal times. (attachment F441 #2) This will include proper handwashing techniques during a meal service and after each direct resident contact. The audits will be brought weekly to morning QA for review. In addition, we will bring the audits to the March monthly QA meeting for further evaluation.</p> <p>Audit results will be reviewed at the March QA meeting to determine the need for additional inservice training and the frequency ongoing audits.</p>	2/19/2011

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER

BAPTIST CONVALESCENT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

120 MAIN STREET
NEWPORT, KY 41071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	<p>Continued From page 10</p> <p>feeding both residents. KMA #1 was observed to repeatedly wipe the residents' mouths and continue spoon feeding each resident. The KMA was not observed to wash or sanitize his hands after wiping one resident's mouth and prior to spoon feeding the other resident.</p> <p>Further observation revealed Licensed Practical Nurse (LPN) #5 asked KMA to come out of the second floor solarium where the residents were being fed to administer a medication to another resident. LPN #5 then sat down and took over feeding Unsampld Resident A and Unsampld Resident B. The LPN proceeded to repeatedly wipe the residents' mouths and continued spoon feeding the residents without washing or sanitizing her hands after wiping the resident's mouths.</p> <p>Interview on 01/27/11 at 1:30 PM with LPN #5 revealed she had received training on feeding residents and should have sanitized or washed her hands after wiping the resident's mouths while feeding on 01/25/11 due to infection control issues.</p> <p>Interview on 01/27/11 at 4:00 PM with KMA #1 revealed he should have washed or sanitized his hands after wiping a residents mouth and prior to spoon feeding the next resident.</p>	F 441		

F-441

#1

N-144

Dining Etiquette

The Who, What, When and Where of Residential Meal Serving

Hand Hygiene

- Wash hands prior to serving meals
- Use hand gel or blue top wipes in between each resident



- Review Preparing resident for a meal

Preparing the Resident

- Perform hand hygiene (HH)
- Oral care (pre or post)
- Make sure resident has their assistive devices
- Assist with elimination if needed (HH)
- Take to dining room
- Clean over bed table with red top wipes
 - Adjust height of table
 - Clipping protectors

F-441

#1

N-144

Use hand gel if you:

- Scratch the scalp
- Run fingers through the hair
- Wipe or touch the nose
- Rubbing an ear
- Touch a pimple or open sore
- Touch a dirty uniform
- Cough or sneeze into the hand
- Spit in the establishment
- Help another resident
- Begin feeding another resident

Serving and Presenting

- No cell phone talk
- Talk to the resident
- No elbows on tables and bored look
- If you must touch the food wear gloves



Serving Drinks

- Drinks may be served prior to the meal
- One straw for each liquid if straws needed



F-441
W-144 #1

Checking the Meal Ticket

- Does the ticket match the meal and consistency ordered
- Diet
 - Regular / NAB / CHO: No seeds, nuts or hulls
- Diet consistency
 - Regular / Mechanical / Pureed
- Liquids
 - Regular nectar, honey or pudding

Regular



Mechanical

- Meat is ground, vegetables are canned or cooked or naturally very soft
- If the meat is ground — needs gravy



F-441 #1
W-144

NAS

- We do not add salt at the table and no salt packet is on the tray when it is served.



Consistent Carbohydrates\ CCHO

- Consistent amount of carbohydrates through out the day
- No added sugar but sugar substitutes
- Sugar free jelly
- Smaller piece of cake



Nectar, Honey, and Pudding Liquids

- Tomato soup can be considered nectar thickened (check consistency - with milk)
- Other soups can be pureed
- Clear pitcher in room



F 441 #1
N 144



QA Review for Pattern Identification

F-441
N-144 #2

AREA OF REVIEW HAND SANITATION DATE _____
 DEPARTMENT NURSING UNIT _____
 EVALUATOR _____ TIME _____
 PERIOD: _____

OTHER INFORMATION: HAND SANITATION FOR EMPLOYEES AND RESIDENTS WHEN RESIDENT IS FED BY STAFF

NAME OR IDENTIFYING INFORMATION Y= YES N= NO FILL IN RESIDENTS NAME, ROOM # UNIT ETC. TO ENABLE CORRECTION OF INDIVIDUAL PROBLEM	STAFF														
	RESIDENT														
		1	2	3	4	5	6	7	8	9	10	YES	NO	%	COMP
STAFF WASH HANDS PRIOR TO SERVING MEALS															
HAVE RESIDENT PERFORM HAND HYGEIN PRIOR TO MEAL BLUE TOP WIPES OR HAND GEL APPROPRIATE															
HANDS ARE SANITIZED IF STAFF DOES ANY OF THE FOLLOWING:	SCRATCH THE SCALP														
	RUN FINGERS THROUGH THE HAIR														
	WIPE OR TOUCH NOSE														
	RUB AN EAR														
	TOUCH A PIMPLE OR OPEN SORE														
	TOUCH YOUR UNIFORM														
	COUGH OR SNEEZE INTO HAND														
	SPIT IN THE ESTABLISHMENT														
	HELP ANOTHER RESIDENT														
BEGIN FEEDING ANOTHER RESIDENT															

COMMENTS/RECOMMENDATIONS

Room	Name	Diet order per chart	Order Correct on diet card	
			Verified by	Date
Audit Date				
201-P				
202-P				
203-1				
203-2				
204-1				
204-2				
205-P				
206-P				
207-1				
207-2				
208-1				
208-2				
209-1				
209-2				
210-1				
210-2				
211-1				
211-2				
212-1				
212-2				
213-P				
214-1				
214-2				
215-1				
215-2				
216-1				
216-2				
217-1				
217-2				
218-1				
218-2				
219-1				
219-2				
220-1				
220-2				
221-P				

F-561
N2876
#1

F 371 continued

All dietary staff has been reeducated on the correct use of tongs and serving utensils. Each food item must have a utensil specifically for that item and cannot be used for any other item during that service as a means to prevent cross contamination. An informal inservice was provided by Donna Frodge, Administrator, on 2/16/11. A formal, mandatory inservice was completed on 2/17/11 by Paula Kuhnen, RN, Staff Development Coordinator.

The administrator will observe the tray line at random meals (at least two per week) to assure adherence to process.

The Dietary Tech is assigned to monitoring the tray line three times a week and observe serving technique. The Tray service sanitation audit (attachment F 371 #4) will be used to document the process and provided to the Quality Assurance Coordinator each week. The results of the QA will be reported each month at the monthly Quality Assurance meeting. Frequency of ongoing audits to be determined by the QA committee based on audit results

Plate warmers have been assessed for cracks or ruptures. All plate warmers have been cleaned and not found to have any white wax like substance on them. Staff has been advised to report any observation of defective warmers to the Administrator for replacements to be obtained. Staff has been directed to remove any questionable warmers from service. Two sales representatives have been contacted to evaluate warmers for any potential defects.

Staff reports the white wax like substance was actually on the serving tray and appeared to be from the heat of the warmer being placed on the tray. All trays have been assessed and scrubbed with wire pads to assure no remnants of wax remain.

Observation of condition of plate warmers and trays will be done by Dietary Technician during monitoring of the tray line audit three times each week. This will also be noted on Dietary Sanitation audit done weekly (Attachment F371 #6) and reported to the Quality Assurance coordinator. Copies of the each will be provided to the Administrator for weekly review, and reviewed monthly at the QA meeting

Dietary Manager has been removed from her position as a result of failure to follow facility policies and procedures and for not assuring the dietary staff follow them also.

Date of compliance: 2/20/2011

Food Temperature Log

Date _____

Breakfast

F 364
N 273

Food Item	Regular		Ground		Puree		MILK		
	First	Mid	First	Mid	First	Mid	First	Mid	
								Store milk in a large bowl with ice to maintain temp. May be out for one meal service only	

Lunch

Food Item	Regular		Ground		Puree		MILK		
	First	Mid	First	Mid	First	Mid	First	Mid	
								Store milk in a large bowl with ice to maintain temp. May be out for one meal service only	

Dinner

Food Item	Regular		Ground		Puree		MILK		
	First	Mid	First	Mid	First	Mid	First	Mid	
								Store milk in a large bowl with ice to maintain temp. May be out for one meal service only	

Hot foods at least 140 degrees

Cold foods no more than 40 degrees

Person(s) completing temp audit:

Breakfast: _____

Lunch: _____

Dinner: _____

F371
N 282 #1

LABELING FOOD

Policy: All opened and prepared food will be labeled and dated prior to it being held for future use.

Procedures:

1. Upon opening food, employees must label and date it, with today's date.
2. Upon food preparation, employees must label and date it, with today's date, prior to it being refrigerated.
3. All beverages must be dated once opened, with today's date
4. All food and beverages must be discarded if not used within 48 hours.

F 371
N 282 #4



Food Hygiene

Serving food safely
"The Food Handler"

How food handlers can contaminate food

- Have a food borne illness
 - Such as GI, Hepatitis A
- Have Infected lesions
- Live with someone who is ill
- AND touching anything that may contaminate the hands



Actions to avoid:

- Scratching the scalp
- Running fingers through the hair
- Wiping or touching the nose
- Rubbing an ear
- Touching a pimple or open sore
- Wearing a dirty uniform
- Coughing or sneezing into the hand
- Spitting in the establishment

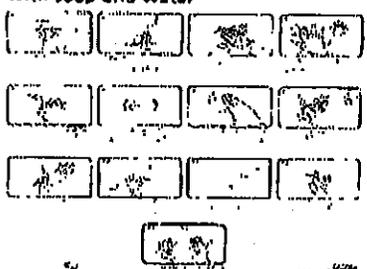
Personal Hygiene Program

- Maintaining personal cleanliness
 - Proper bathing
 - Hair washing
- Wearing proper work attire
 - Hair restraint
 - Appropriate shoes
 - Clean clothing
 - Removing jewelry from hands and arms
- Following hand hygiene
 - Hand washing
 - Hand maintenance
 - Proper glove use

Wash Your Hands For At Least 20 Seconds.



Hand-washing technique with soap and water NTP



Also

- Keep fingernails clean and short
- Do not wear false nails
- Bandage cuts and cover bandages



F-371
 W-282 #4

Wash Your Hands After:

- Using the restroom
- Handling raw meat, poultry and fish
- Touching the hair, face, or body
- Sneezing, coughing, or using a tissue
- Smoking, eating, drinking or chewing gum or tobacco
- Handling chemicals that may affect the safety of food
- Taking out the garbage

Wash Your Hands After:

- Cleaning tables or bussing dirty dishes
- Touching clothing or aprons
- Touching anything that may contaminate hands, such as unsanitized equipment, work surfaces or wash cloths



Gloves

No bare hand contact with food

- Use disposable gloves
- Never used instead of hand washing
- Change gloves as soon as they become soiled or torn
- Before beginning a different task
- At least every 4 hours for continual use and more if necessary
- After handling raw meat and before handling cooked or ready to eat food

Food Handlers

Food handlers must not:	When:
Smoke	Preparing or serving food
Chew gum or tobacco	Working in food prep areas
Eat or drink	Working in a area to clean utensils /equip

Do not work in the kitchen when:

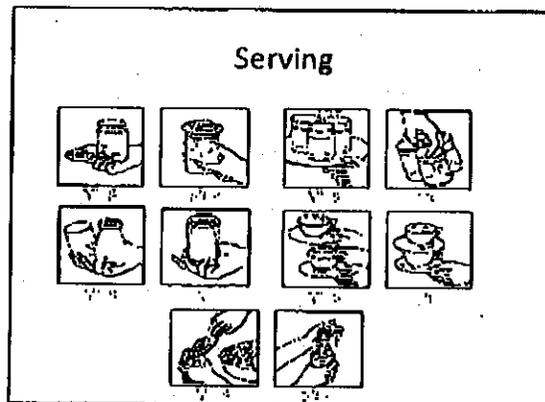
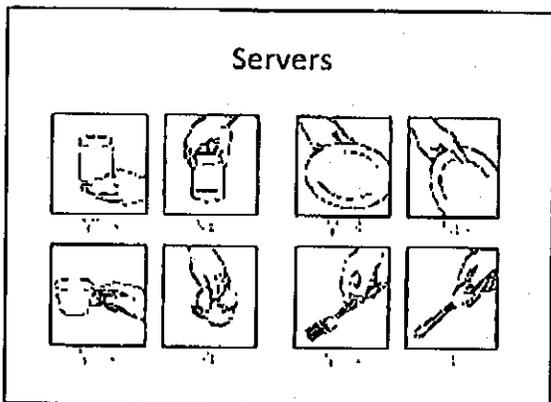
- Sore throat with fever
- Vomiting
- Diarrhea
- Jaundice





spot the hazards

F-371 #4
N-282



Covered, Dated, and Labeled

- Label all food
- The label must include the name of the food and the date it was prepared
- We keep food no longer than 48 hours post date on label
- Employees must place their name and date on food also

Bread pudding 3/14/2011

F 371
N 282 #5

**QA REVIEW
TRAY SERVICE SANITATION**

AREA _____

DATE _____

DEPARTMENT DIETARY

AREA TRAY SERVICE

EVALUATOR _____

TIME _____

STANDARD: THE FACILITY MUST PROCURE FOOD FROM SOURCES APPROVED OR CONSIDERED SAFE BY FEDERAL, STATE OR LOCAL AUTHORITIES AND STORE, PREPARE AND SERVE FOOD UNDER SANITARY CONDITIONS			
INDICATORS	YES	NO	COMMENT
DURING MEAL SERVICE			
HAIR NETS COVER ALL OF HAIR ON HEAD			
HANDS WASHED PRIOR TO FOOD PREP			
GLOVES WORN IF APPROPRIATE			
GLOVES CHANGED DURING PROCESS IF APPROPRIATE/NEEDED			
TEMP LOG - RECORDED AT BEGINNING OF MEAL			
TEMP LOG - RECORDED MID MEAL			
TEMPERATURES CORRECT FOR ITEM SERVED			
SEPARATE SERVING UTENSIL USED FOR EACH FOOD ITEM			
NO STAINED CUPS/GLASSES USED			
NO CRACKED TRAYS USED			
PLATE WARMERS INTACT - NO EVIDENCE OF LEAKING			
ADAPTIVE FEEDING UTENSILS CORRECT			
TRAY CARTS/COVERS CLEAN AND INTACT			
AFTER MEAL			
FOOD APPROPRIATELY COVERED FOR STORAGE			
FOOD APPROPRIATELY LABELED AND DATED FOR STORAGE			

% COMPLIANCE _____

F 371 #6
N 282

DIETARY - SANITATION REPORT

FACILITY: _____ DATE/TIME: _____

ITEM	YES	NO	COMMENTS	ITEM	YES	NO	COMMENTS
Stock Room				Prep/Cooking Area			
Temperature (50-70 degrees)				Cleanliness			
Temperature recorded				Equipment clean/good condition			
Well-lighted				Range/Stove/Grill			
No dented cans - designated area				Oven			
Light fixtures/covers				Oven - convection			
Shelving				Steam table			
Stock dated/rotated				Fryer			
Open ingredients - sealed container				Mixer (covered)			
6" off floor / 18" from ceiling				Food processor			
Walls/ceilings				Blender			
Neat/orderly				Meat slicer (covered)			
No Chemicals stored here				Can opener/blade			
Emergency Food				Toaster			
Refrigerator/Freezer				Microwave			
Walk In				Coffee maker			
Clean/good condition				Ice machine			
Internal Thermometer				Utensils			
Proper Temperature/recorded				Dishes - clean, no chips			
Gasket/seal				Silverware			
Stock dated/rotated				Cutting Boards (not wood)			
Light fixtures/covers				Knives (not wood handles)/tray			
Leftovers labeled, dated and covered				Trays (no chips/cracks)			
Leftovers disposed per policy							
Cooked foods stored above raw foods							
6" - floor / 18" - ceiling							

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 139 MAIN STREET
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
K 051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was</p>	K 051	<p>Preparation or execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed, as required by the provision of federal and state law.</p> <div style="text-align: center; border: 1px solid black; padding: 5px; width: fit-content; margin: 20px auto;"> <p>RECEIVED</p> <p>FEB 18 2011</p> <p>BY: _____</p> </div>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Caul Patrick AA</i>	TITLE	(X6) DATE 2/18/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185088	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 051 Continued From page 1
determined the facility failed to ensure that fire alarm pull boxes were mounted correctly. According to the standard of the National Fire Protection Association (NFPA) 72. The Fire Alarm Code.

The findings include:

Observation, during the Life Safety Code survey, on 01/27/11 at 10:35 AM, revealed the fire pull initiation device at the East and West exits on floors 2A, 3A and 4A for a total of six (6) was mounted at a height of sixty (60) inches above the floor surface. Fire Pull Station devices shall be installed a minimum of three and a half (3.5) feet and maximum of four and a half (4.5) feet above floor level. The deficiency has the potential to affect nine (9) smoke compartments and one hundred and eight (108) residents and staff. The facility is licensed for one hundred and sixty-seven (167) and the day of the survey the census was one hundred and sixty-three (163).

Interview with the Maintenance Director on 01/27/11 at 10:36 AM, indicated he did not realize the pull initiation device was mounted too high and had been that way for years.

Reference: NFPA 72 (1999 Edition)
2-8.1 Mounting.

Each manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 31/2 ft (1.1 m) and not more than 41/2 ft (1.37 m) above floor level.

K 072 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

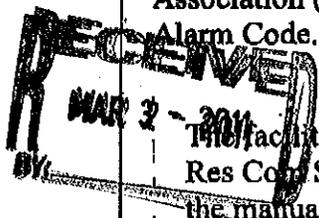
K 051

K 072

K 051 NFPA 101 LIFE SAFETY CODE STANDARD

Facility failed to ensure that fire alarm pull boxes were mounted correctly. According to the standard of the National Fire Protection Association (NFPA) 72. The Fire Alarm Code.

The facility has arranged with Res Com Security to replace the manual fire alarm boxes that did not meet code. All boxes will be moved if needed to be no less than 3 1/2 feet and not more than 4 1/2 feet above floor level. Res Com has committed to having the work completed by March 11th, 2011.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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ID PREFIX TAG	DEFICIENCY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 072	<p>Continued From page 2</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that corridors were maintained free from obstructions to the full instant use in the case of fire or other emergencies. Exits must be maintained to ensure their use in an emergency. The deficiency has the potential to affect all staff and residents.</p> <p>The findings include:</p> <p>Observation on 01/27/11 at 10:15 AM, revealed medication carts were stored and not in use in front of the nursing stations at the Fourth Floor Nurses Station, Third Floor Nurses Station and Second Floor Nurses Station. Also, noted during the survey, were clean linen carts stored and not in use in the corridor outside of the Bathing Room on the third floor. Further observation revealed three (3) wheelchairs were stored and not in use in the corridor outside of Rooms 304, 305 and 306 on the third floor; and, Rooms 204 and 213 on the second floor. This deficiency has the potential to affect all staff and residents. The facility is licensed for one hundred and sixty-seven (167) beds. The census was one hundred and sixty-three (163) the day of the survey. The observations were confirmed with the Maintenance Director.</p>	K 072	<p>K 072 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <ul style="list-style-type: none"> All nursing staff was educated regarding the appropriate placement and storage of medication, treatments and linen carts. (2/18/11) The second, third, and fourth floor medication carts will be stored in the recessed area on each unit. The treatment carts on the second, third, and fourth units will be stored in the storage closet on each unit. All nursing staff was educated regarding the appropriate storage of wheelchairs. (2/18/11) 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 3 Interview, on 01/27/11 at 10:16 AM, with the Maintenance Director, revealed they would in-service staff the importance of keeping the corridors clear. Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 072	<ul style="list-style-type: none"> The wheelchairs on the second, third and fourth floors of the A building will be stored in the <i>short term</i> storage area on each unit. Wheelchairs in the C building will continue to be stored in the residents room when not in use 	2/18/2011
K 130 88=D	<p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. They shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p> <p>The findings include:</p> <p>Observation on 01/27/11 at 12:10 PM with the Maintenance Director, revealed that an unapproved lock (slide bolt type) was installed on the inside of the kitchen door. The deficiency would not allow the occupants to exit the kitchen at their will in the event of an emergency.</p> <p>Interview on 01/27/11 at 12:10 PM with the Maintenance Director, revealed he did not know</p>	K 130	<p>K130 NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>The facility failed to maintain doors within a required means of egress. They shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p> <ul style="list-style-type: none"> The slide bolt was removed from the kitchen door on 1/27/11. An informal education was given to all dietary staff regarding inappropriate locking of exit doors on 2/18/11 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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K 130	<p>Continued From page 4 why the dead bolt was on the door and would remove the lock.</p> <p>NFPA 101 2000 Edition.</p> <p>10.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p> <p>Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that</p> <p>10.2.2.2.5)</p> <p>Exception No. 2: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.</p> <p>Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p>	K 130	<ul style="list-style-type: none"> The door was patched and painted by maintenance staff This facility prohibits the use of slide bolt locks on any doors that are a means of egress. 	2/18/11