

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

PRINTED: 08/13/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2010
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NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF BENTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025
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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 An annual survey was conducted 07/27-30/10 to determine the facility's compliance with Federal Regulatory Requirements. Deficiencies were identified with the highest S/S being an "E".	F 000	<u>RESPONSE PREFACE</u> Britthaven acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Britthaven's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Britthaven reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding. Resident #3 received medication starting on June 22, 2010 and has shown no symptoms of a urinary tract infection. No further action is indicated. Resident #4 received medication starting on July 28, 2010 and has shown no symptoms of a urinary tract infection. No further action is indicated. Resident #5 shows no symptoms of a urinary tract infection. Attending physician	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8-29-10
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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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F-157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record reviews, it was determined the facility failed to ensure the physician was notified of lab results in a timely manner for three residents (#3, #4 & #5), in the selected sample of 19. Findings include:</p> <p>1. A record review revealed Resident #3 was admitted to the facility with diagnoses to include Urinary Tract Infection, Septic Shock, Acute Renal Insufficiency, Severe Coagulopathy and Anemia.</p> <p>A review of a urinalysis/culture & sensitivity (UAC&S) report revealed a collection date per catheterization of 06/18/10, with a result received date of 06/18/10, which was faxed to the physician's office on 06/18/10. The results of the test revealed the urine contained more than 100,000 CFU/ML of Escherichia Coli (E coli), which indicated the resident had a urinary tract infection. A physician's order was obtained, on 06/22/10, (four days later) for Macrobid (antibiotic) 100 milligrams (mg) orally (po) twice per day (bid) for 15 days.</p> <p>A review of a UAC&S report revealed a collection date per catheterization of 07/21/10, with a result received date of 07/23/10, which was faxed to the physician's office on 07/23/10. The results revealed the resident's urine contained more than 100,000 CFU/ML E coli. A physician's order was not obtained, until 07/28/10, five days later, for Rocephin (injectable antibiotic) one (1) gram (gm) intramuscular (IM) every day for seven (7) days.</p> <p>2. A record review revealed Resident #4 was</p>	F 157	<p>notified on August 2, 2010. No new orders received.</p> <p>Any resident having abnormal lab results has the potential to be affected by this deficient practice. A 100% audit has been completed for all labs that were found to be abnormal from August 1, 2010 through August 26, 2010. The audit includes the date the lab was received to this facility, the date the physician was notified of the abnormal lab, and the date the physician responded to the abnormal lab. The results of the audit revealed communications to the physician were met in a timely manner.</p> <p>Attending physicians will be contacted the day the abnormal lab is received for instructions regarding the course of treatment.</p> <p>Nursing staff in-serviced on Thursday, August 19, 2010 regarding ensuring the physician is notified of lab results in a timely manner. Six employees did not attend the in-service. Those employees received make-up in-services on or before Saturday, August 28, 2010. Upon</p>

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F 157	<p>Continued From page 2</p> <p>admitted to the facility with diagnoses to include Gastroesophageal Reflux Disease, Cerebral Infarct Cystitis, Prolapsed Mitral Valve and Vertigo.</p> <p>A review of a UA/C&S report, revealed a collection date per catheterization of 06/15/10, with a results received date of 06/17/10, which were faxed to the physician's office on 06/17/10. The results revealed the resident's urine contained more than 100,000 CFU/ML E coli. A physician's order was not obtained, until 06/21/10 (four days later), for Macrobid 100 mg po bid for one week.</p> <p>An interview with the Director of Nursing (DON), on 07/29/10 at 10:00 AM, revealed whenever results of a UA/C&S were obtained at the facility, staff faxed the results to the physician's office. The fax confirmation sheets were kept to ensure the physician received the lab reports. If there were critical values or the resident was having symptoms, the nurse was supposed to call the physician's office. If not critical, the staff waited for the physician to respond by calling the facility, after receipt of the fax. The DON stated the facility should be in contact with the physician sooner, whether the facility received an order to treat or not.</p> <p>3. A record review revealed Resident #5 was admitted to the facility with a diagnosis of Chronic Kidney Disease.</p> <p>A record review revealed an order was received, on 07/20/10, to obtain a urine specimen for a urinalysis. The urine specimen was obtained and sent to the lab; however, the lab did not complete the testing, due to the specimen was not labeled.</p>	F 157	<p>receipt of this statement of deficiencies employees were re-educated prior to their next scheduled shift. The ward clerk will audit all abnormal labs to ensure the physician was contacted in a timely manner for one month. Results of this audit will be reviewed by the Director of Nurses. After one month if the deficient practice has been resolved a 25% audit of all abnormal labs will continue on a monthly basis. Results will be reviewed by the Director of Nurses and presented during the Quarterly Quality Assurance meeting with the Medical Director.</p>	08/29/2010	

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F 157	<p>Continued From page 3</p> <p>The facility did not obtain another urine specimen, until 07/23/10. A review of the UA/C&S report revealed the urine protein level was 30, Hyaline Casts were 0-4 and the culture and sensitivity report revealed a Gram Positive bacteria, which indicated an abnormal result. The results were faxed to the physician's office on 07/26/10. There was no evidence provided to verify the physician received the results and no new orders had been received as of 07/30/10, the last survey date.</p> <p>Interviews with the DON, on 07/29/10 at 5:20 PM and on 07/30/10 at 9:30 AM, revealed the physician was not called to verify the receipt of the lab results. The DON stated in both incidences regarding Resident #5, the physician's office should have been notified. As of 07/30/10 at 2:30 PM, the physician had not been contacted.</p> <p>A review of the facility's policy/procedure, "Notification of Physician for Change in Resident's Condition," dated 04/07 revealed, "It is the policy of the facility to notify the physician when a significant change in a resident's condition occurs with documentation."</p>	F 157		
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p>	F 164	<p>Resident #11 will receive personal privacy and confidentiality of his or her personal and clinical records. The administrator demonstrated to all staff the occurrence which occurred with resident #11 during the in-service. Demonstrations also occurred during the make-up in-services. Demonstration included verbal description of how this resident was using the toilet in full</p>	

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F 164	<p>Continued From page 4</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</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 privacy was provided for one resident (#11), in the selected sample of 19, related to incontinent care. Findings include: A record review revealed Resident #11 was admitted to the facility with diagnoses to include Dementia Neuropathy, Hypertension, Diabetes Type II and Osteopenia. A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/24/10, revealed the facility assessed the resident as moderately cognitively impaired and occasionally incontinent of bowel and frequently incontinent of bladder, requiring extensive assistance of two staff members with activities of daily living. Although the resident was not interviewable, the facility identified the resident's</p>	F 164	<p>view of the roommate. Social Services interviewed the roommate, who is alert and oriented if privacy is being provided. The interview revealed that she has had no problems with privacy. Resident #11 is not interviewable. Resident #11 is able to ambulate with assistance to the bathroom. Ambulation to the bathroom is now reflected on the careplan, care guide and the 24-hour shift report.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Staff re-educated during an in-service on Thursday, August 19, 2010 regarding a resident's right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. Six employees did not attend the in-service. Those employees received make-up in-services on or before Saturday, August 28, 2010. Upon receipt of this statement of deficiencies</p>	
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F 164	Continued From page 5 ability to make needs known. An observation on 07/29/10 at 7:40 PM, revealed the resident was sitting in his/her room in a wheelchair. Two staff members entered the resident's room and proceeded to assist Resident #11 to the bathroom, located in the resident's room. The staff did not close the bathroom door and the resident's roommate was awake and had full visual accessibility of the resident inside the bathroom. An interview with Licensed Practical Nurse #2, on 07/30/10 at 1:55 PM, revealed she realized the door to the bathroom was left open. The location of the wheelchair prevented the staff from closing the bathroom door. She stated she was unsure how to provide appropriate privacy and safety at the same time.	F 164	employees were re-educated prior to their next scheduled shift. The Staff Development Coordinator will conduct a resident care audit for 20 different residents a week times four weeks. The audit will be conducted over all shifts. Over the course of the audit all nursing assistants will be observed. The Resident Care Audit includes the following items: date, staff member observed, care activity observed, if the care performed was correct per procedure, if dignity/privacy was provided during care, if the care performed was incorrect details of the retraining, signature of the employee who performed the retraining, auditor signature. The results of these audits will be presented to the Director of Nurses. Once determined that the deficient practice has been corrected, audits will continue at a rate of 20 residents per month to ensure the deficient practice does not reoccur. Results of these findings will be presented during the Quarterly Quality Assurance meeting which includes the Medical Director.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services provided by the facility met professional standards of quality. Observation during three different medication passes revealed three residents (#20, #21, and #22), not in the selected sample, were administered medications that were not accordance with physicians' orders. Findings include: 1. An observation during a medication pass, on	F 281		08/29/2010

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F 201	<p>Continued From page 8</p> <p>07/27/10 at 2:57 PM, revealed Kentucky Medication Aide (KMA) #1 administered one Metformin (regulates blood glucose) 500 milligrams (mg) tab to Resident #20. A review of the physician's orders and the Medication Administration Record (MAR), dated 07/01/10 to 07/31/10, revealed the Metformin 500 mg was scheduled for administration at 8:00 AM and 5:00 PM. The medication was administered early and resulted in a medication error.</p> <p>An interview with KMA #1, on 07/29/10 at 11:30 AM, revealed she had an hour before or after the scheduled time to administer medication. She felt she had followed the timeframe, prior to being approached by the Director of Nursing (DON). KMA #1 stated, "I now realize I gave the medication too early. I just got in a hurry".</p> <p>2. An observation during the medication pass, on 07/27/10 at 3:15 PM, revealed KMA #2 administered one Metformin 500 mg tab to Resident #21. A review of the physician's orders and the MAR, dated 07/01/10 to 07/31/10, revealed the Metformin 500 mg tab was scheduled for administration at 8:00 AM, at 12:00 Noon, and at 5:00 PM with meals/food. The medication was administered early and was not given with food, resulting in a medication error.</p> <p>3. An observation during a medication pass, on 07/27/10 at 3:19 PM, revealed KMA #2 administered Metformin 500 mg tab to Resident #22. A review of the physician's orders and the MAR, dated 07/01/10 to 07/31/10, revealed the Metformin 500 mg tab was scheduled to be administered at 8:00 AM and at 5:00 PM. The medication was administered early and resulted in a medication error.</p>	F 201	<p>Residents #20, #21, #22 will receive medications that are in accordance with physicians' orders. These services will be provided and meet professional standards of quality. The Director of Nurses upon notification during the survey process of the medication error, immediately counseled the KMAs involved in providing medications outside of the accepted timeframe for residents #20, #21 and #22.</p> <p>All residents have the potential to be affected by this deficient practice of professional standards.</p> <p>Those staff members who administer medications were re-educated regarding professional standard and facility policy of providing medications. Those employees received make-up in-services on or before Saturday, August 28, 2010. Upon receipt of this statement of deficiencies employees were re-educated prior to their next scheduled shift.</p> <p>The Quality Assurance Nurse will complete five medication administration audits per week times</p>		

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F 281	Continued From page 7 A review of the policy entitled, "Routine Hours of Medication Administration", revised 08/10/04, revealed routine medications could be administered approximately one hour before or after the time indicated on the MAR. An interview with KMA #2, on 07/27/10 at 6:05 PM, revealed he had an hour before or after the scheduled time to administer medications. He stated he was aware of the order to administer Metformin at 5:00 PM, but he administered it early, so he could keep up with the other duties he was assigned. An interview with the DON, on 07/29/10 at 10:15 AM, revealed she reminded the staff they had an hour before or after the scheduled time to administer medications, after receiving information from the surveyor regarding the administration of medications earlier than scheduled. She stated no supervisor on the floor had reported any problems with medications not being given within acceptable timeframes. She stated the medication policy reflected staff could exceed the hour time, but should not give medications earlier than scheduled. The DON stated she expected staff to administer the medication as ordered by the physician and within the timeframe. An interview with the physician, on 07/29/10 at 12:21 PM, revealed it was not good practice to administer the medication early and he preferred the medication be administered within the time constraints of the program. A review of the manufacturer's recommendations revealed Metformin should be given in divided	F 281	four weeks. Each week five different employees will be monitored over all shifts. All employees who administer medications will be observed during the course of the audit. The results of these audits will be presented to the Director of Nurses. If non-compliance is identified disciplinary action will be taken. Once the deficient practice has been resolved the audits will continue at a rate of ten per month including ten different residents with a minimum of five different employees. The results of these audits will be presented during the Quarterly Quality Assurance meeting.	08/29/2010	

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F 281	Continued From page 8	F 281		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure care was provided in accordance with the resident's plan of care for one resident (#10), in the selected sample of 19. The facility failed to ensure Resident #10's clip alarm was implemented in accordance with the care plan. Findings include:</p> <p>A record review revealed Resident #10 was admitted to the facility with diagnoses to include Profound Orthostatic Hypotension, Irritable Bowel Syndrome and Osteoporosis.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/28/10, revealed the facility assessed Resident #10 as moderately cognitively impaired and requiring extensive assistance of one staff member to transfer.</p> <p>A review of the comprehensive care plan, "Risk for Falls," dated 03/09/10, revealed interventions to provide a personal alarm to the bed and the chair.</p> <p>Observations, on 07/27/10 at 6:00 PM and on 07/28/10 at 10:40 AM, revealed the resident was</p>	F 282	<p>Resident #10 was assessed for safety interventions related to a history of falls on July 30, 2010. It was determined that the resident would benefit from a sensor alarm. The care plan and resident care guide were updated on July 30, 2010.</p> <p>All residents have the potential to be affected by this deficient practice regarding services provided or arranged by the facility in accordance to the resident's written plan of care.</p> <p>The charge nurse is responsible for reviewing the list of devices as assessed and implemented from the resident's plan of care. Staff were re-educated during an in-service on Thursday, August 19, 2010. Those employees who were unable to attend the in-service received make-up in-services on or before Saturday, August 28, 2010. Upon receipt of this statement of deficiencies employees were re-educated prior to their next scheduled shift.</p>	

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F.282	<p>Continued From page 9</p> <p>up in a wheelchair and the clip alarm was not attached to the resident. An observation, on 07/29/10 at 11:40 AM, revealed the resident was sitting in a recliner in his/her room. The wheelchair was nearby and the clip alarm was attached to the wheelchair and was turned off.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1, on 07/30/10 at 11:40 AM, revealed she attempted to ensure alarms were in place, during rounds; however, she depended on the nurse and the Resident Care Guide (nurse aide care plan) to keep her updated on any new interventions, such as alarms. Although, she made rounds, she did not always review the Resident Care Guide until mid-morning or whenever she had an opportunity. She stated she had access to the Resident Care Guide, the entire shift and signed off on the care guide at the end of the shift, which indicated all care had been provided.</p> <p>An interview with Registered Nurse (RN) #1, on 07/30/10 at 11:25 AM, revealed she was responsible as the charge nurse to check alarms during rounds; however, the action was not documented. She stated the resident had a new sensor alarm initiated in the wheelchair, on 07/30/10, and the clip alarm was discontinued.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 07/29/10 at 11:30 AM, revealed Resident #10 had a history of falls and had been assessed as a high risk for falls. The resident was capable of self transfer, at times. A clip alarm was utilized to help ensure ensure safety. It was the responsibility of all staff to ensure the alarms were in place and functioning, for each of the residents. The DON stated the resident did not</p>	F.282	<p>The Quality Assurance Nurse will update the list of devices, care plan, resident's care guide as well as communicating any changes in devices on the 24-hour shift report. The Quality Assurance Nurse will conduct a 100% audit for all devices weekly times four weeks. The results of this audit will be presented to the Director of Nurses. Once the deficient practice has been resolved the audits will continue at a rate of 25% of all residents weekly. The results of these audits will be presented during the Quarterly Quality Assurance meeting.</p> <p>08/29/2010</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2010
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F 282	Continued From page 10 remove or turn the clip alarm off. The DON stated she checked the battery supply on each unit on Mondays and conducted occasional audits on the use of the alarms. A review of the facility's policy/procedure, "Resident Care Plan," dated 04/07, revealed "development and implementation of the care plan will occur by participating disciplines available in the facility at a team conference under the direction of the RN Coordinator. The resident care plan will be an ongoing process and will include current problems and/or needs identified from a complete assessment."	F 282		
F 315 SS=D	483.26(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure appropriate care for an indwelling catheter was provided for two residents, (#9 and #13), in the selected sample of 19. Findings include: 1. A record review revealed Resident #13 was	F 315	Residents #9 and #13 will receive appropriate care for an indwelling catheter to prevent urinary tract infections. One SRNA is no longer employed with this facility. The other SRNA who was identified during the survey was counseled regarding the correct procedure for catheter care for resident #9 and #13 by the Director of Nurses on July 29, 2010. All other employees were re-educated during the staff in-service or make-up in-services. Any resident who has an indwelling catheter has the potential to be affected by this deficient practice. Nursing staff were re-educated on Thursday, August 19, 2010 regarding	

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F 315	<p>Continued From page 11</p> <p>admitted to the facility on 03/13/08, with diagnoses to include Neurogenic Bladder with spasms, Urinary Retention, Multiple Sclerosis (Mid-Late Stage), Renal Insufficiency, and Urinary Tract Infection with Pseudomonas.</p> <p>A review of the quarterly Minimum Data Set assessment (MDS), dated 06/23/10, revealed the facility assessed Resident #13 to be moderately impaired with decision making and requiring total assistance of two staff members with all activities of daily life (ADLs). Resident #13 had an indwelling catheter and was incontinent of bowel.</p> <p>An observation, on 07/29/10 at 2:10 PM, revealed State Registered Nurse Aides (SRNA) #3 and #4 failed to wash their hands, but donned gloves prior to provision of catheter care for Resident #13. Observation revealed the resident had a large incontinent episode and loose stool was on the resident's bed, gown, sheets and bedspread. SRNAs #3 and #4 provided incontinent care with gloves covered with a very large amount of stool. SRNA #4 was observed to use a peri-wipe and remove stool from the glove worn by SRNA #3 and then continued the incontinent care. Observation revealed SRNA #3 touched the resident's indwelling catheter tube with the soiled gloves three times during care. SRNA #4 was observed to wipe the catheter tubing repeatedly with one peri-wipe.</p> <p>2. A record review revealed Resident #9 was admitted to the facility with diagnoses to include Pyelonephritis, Nephrolithiasis, Benign Prostatic Hypertrophy (BPH), Urinary Retention, and Alzheimer's Dementia.</p> <p>A review of the quarterly MDS, dated 06/16/10,</p>	F 315	<p>the proper procedure for catheter and incontinent care. Those employees not attending the in-service received make-up in-services on or before Saturday, August 28, 2010. Upon receipt of this statement of deficiencies employees were re-educated prior to their next scheduled shift.</p> <p>The Staff Development Coordinator will monitor nursing staff providing catheter care to all residents who have a catheter twice weekly times four weeks. The Staff Development Coordinator will monitor nursing staff providing incontinent care for ten different residents per week times four weeks. Observations will occur over all shifts with different employees each time. In the event of non-compliance the Staff Development Coordinator will provide correct demonstration and education to ensure appropriate care. The results of these audits will be reviewed by the Director of Nurses. Once the deficient practice has been resolved the audits will continue at a rate of ten different residents per month with a minimum of two of the residents having catheters. The</p>	
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F 315	Continued From page 12 revealed the facility assessed Resident #9 as moderately impaired with decision making and requiring extensive assistance with all ADLs. The resident was incontinent of bowel and had an indwelling catheter. An observation, on 07/29/10 at 2:45 PM, revealed SRNAs #3 and #4 did not wash their hands before or after provision of incontinent care for Resident #9. Observation revealed the resident had a bowel movement during the provision of incontinent care. SRNA #4 touched the catheter tubing three times with a soiled peri-wipe. Both of the SRNAs wore the same soiled gloves while transferring the resident into a wheelchair. Interviews with SRNA #3 and SRNA #4, on 07/29/10 at 3:20 PM and 3:36 PM, revealed neither aide realized they touched the resident's catheter tubing with soiled gloves or a peri-wipe. An interview with the facility's Staff Development Coordinator, on 07/29/10 at 5:05 PM, revealed staff members were provided education on perineal care and catheter care, during orientation. Staff members were required to provide a return demonstration of proper care to the perineal area and catheter care. She provided an in-service, on 06/18/10, related to catheter care. The in-service was presented as part of routine perineal care and after each incontinent episode.	F 315	results of these audits will be presented during the Quarterly Quality Assurance meeting.	08/29/2010	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	Resident #10 was assessed for safety interventions related to a history of falls on July 30, 2010. It was determined that the resident would benefit from a sensor alarm. The care plan and resident care guide were		

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F 323	Continued From page 13 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure three residents (#10, #11 & #15), in the selected sample of 19, remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents. Resident #10 had a history of falls and the facility failed to ensure the use of a clip alarm was consistently implemented. Resident #11's bed alarm was not functioning on 07/08/10 and the resident sustained a fall. Resident #15's medications were left at the bedside unattended for an undetermined amount of time. Findings include: 1. A record review revealed Resident #10 was admitted to the facility with diagnoses to include Profound Orthostatic Hypotension, Autonomic Dysfunction, Irritable Bowel Syndrome and a history Hepatitis C and Osteoporosis. A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/28/10, revealed the facility assessed Resident #10 as moderately cognitively impaired and requiring extensive assistance of one staff member with transfers. A review of the comprehensive care plan, "Risk for Falls," dated 03/09/10, revealed interventions included a personal alarm to the bed and the chair. A review of a current Resident Care Guide (nurse aide care plan) revealed, "Special	F 323	updated on July 30, 2010. Resident #11 bed alarm was assessed on Monday, August 17, 2010 to ensure it is functioning properly. Resident #15 will receive medications per the facility's policy and procedure for "Administration of Oral (PO) Medications". All residents have the potential to be affected by this deficient practice. The charge nurse is responsible for reviewing the list of devices as assessed and implemented from the resident's plan of care. Staff were re-educated during an in-service on Thursday, August 19, 2010. Those staff members who administer medications were re-educated regarding professional standard and facility policy of providing medications on Thursday August 19, 2010. Those employees not attending the in-service received make-up in-services on or before Saturday August 28, 2010. Upon receipt of this statement of deficiencies employees were re-educated prior to their next scheduled shift.	
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F 323	<p>Continued From page 14</p> <p>precautions for falls - non-skid footwear, encourage to call for assistance and bed/chair alarms." A review of the facility's falls investigations revealed Resident #10 had a history of falls related to unassisted transfers and attempts to ambulate on his/her own.</p> <p>Observations, on 07/27/10 at 6:00 PM and on 07/28/10 at 10:40 AM, revealed the resident was in a wheelchair and the clip alarm was not attached to the resident. An observation, on 07/29/10 at 11:40 AM, revealed the resident was sitting in a recliner in his/her room and the clip alarm was observed attached to the back of the wheelchair nearby and was turned off.</p> <p>An interview with SRNA #1, on 07/30/10 at 11:40 AM, revealed she attempted to ensure alarms were in place during rounds; however, she depended on the nurse and the nurse aide care plan to keep her updated on any new alarms. She had made rounds and did not always look at the nurse aide care plan until mid-morning or whenever she got a chance to look at it. She stated she had access to the nurse aide care plan and signed off on the care plan, indicating all care was provided. She was unsure of the type of alarm the resident required.</p> <p>An interview with Registered Nurse (RN) #1, on 07/30/10 at 11:25 AM, revealed it was her responsibility as the charge nurse to check alarms during rounds. She revealed the resident received a new sensor alarm for his/her wheelchair, on 07/30/10 and no longer had a clip alarm on the wheelchair. It was her responsibility to ensure the staff in her area were aware of new or added interventions as soon as possible; however, she had not had time to inform SRNA</p>	F 323	<p>Regarding the use of devices to prevent falls the Quality Assurance Nurse will update the list of devices, care plan, resident's care guide as well as communicating any changes in devices on the 24-hour shift report. The Quality Assurance Nurse will conduct a 100% audit for all devices weekly times four weeks. The results of this audit will be presented to the Director of Nurses. Once the deficient practice has been resolved the audits will continue at a rate of 25% of all residents weekly. The results of these audits will be presented during the Quarterly Quality Assurance meeting.</p> <p>In regards to the administration of oral medications the Quality Assurance Nurse will complete five medication administration audits per week times four weeks. Each week five different employees will be monitored over all shifts. All employees who administer medications will be observed during the course of the audit. The results of these audits will be presented the Director of Nurses. If non-compliance is identified disciplinary action will be taken. Once the</p>	
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F 323	Continued From page 15 #1 about the new alarm for Resident #10. 2. A record review revealed Resident #11 was admitted to the facility with diagnoses to include Dementia Neuropathy, Hypertension, Diabetes Type II and Osteopenia. A review of the quarterly MDS assessment, dated 05/24/10, revealed the facility assessed the resident as moderately cognitively impaired and requiring extensive assistance of one to two staff members with activities of daily living (ADLs). A review of the comprehensive care plan, "Risk for Falls," updated 02/18/10, revealed interventions included a bed alarm. A review of a current nurse aide care plan revealed, "Special precautions for falls - non-skid footwear, keep personal items within reach, mat on the floor beside the bed, toilet frequently or as needed, and a bed alarm." A review of the facility's investigation dated 07/08/10, revealed the resident's bed alarm did not sound when the resident was found sitting on the floor beside his/her bed. The resident was not injured and the resident was attempting to go to the bathroom unassisted. An interview with Licensed Practical Nurse (LPN) #1, on 07/29/10 at 11:30 AM, revealed Resident #11 was assessed at high risks for falls. He/she transferred him/herself unassisted at times. A bed alarm was implemented for Resident #11. She stated it was all staff members' responsibility to ensure the alarms were in place and functioning for each resident. She stated she checked the battery supply on each unit on Mondays and performed occasional audits on the alarms, as	F 323	deficient practice has been resolved the audits will continue at a rate of ten per month including ten different residents with a minimum of five different employees. The results of these audits will be presented during the Quarterly Quality Assurance meeting.	08/29/2010
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F 323	<p>Continued From page 16</p> <p>well as physically checked the alarms at times. There was no specific or set time for checking the placement or functioning of the alarms.</p> <p>There was no evidence of a policy/procedure related to alarms.</p> <p>3. A record review revealed Resident #15 was admitted to the facility with diagnoses to include Cellulitis Left Lower Extremity, Cardiopulmonary Disease, Diabetes and Hypertension. The resident was transferred to the hospital, on 07/25/10 at 8:10 AM, due to an altered mental status change.</p> <p>An observation during tour, on 07/27/10 at 11:15 AM, revealed a cup of four pills was located on the resident's bedside table. Two pills were identified as Neurontin (anti-epileptic) 100 milligrams (mg) capsules, one pill was Magnesium Oxide 400 mg tablet and one pill was Vitamin D3 1000 IU tablet.</p> <p>A review of the physician's orders, dated 07/01/10 through 07/31/10 revealed, Neurontin 100 mg (two tablets) by mouth (po) every night at bedtime was scheduled for administration at 8:00 PM. The order for the Mag Oxide 400 mg tablet po twice daily (bid) was scheduled for administration at 8:00 AM and at 8:00 PM. The order for Vitamin D3 1000 IU tablet po bid was scheduled for administration at 8:00 AM and at 4:00 PM.</p> <p>A review of the July medication administration record (MAR), revealed the medications were last documented as administered on 07/24/10, at the scheduled times. A review of the July MAR revealed on the morning of 07/25/10, all medications were withheld.</p>	F 323			

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F 323	Continued From page 17 An interview with LPN #2, on 07/27/10 at 3:10 PM, revealed she was responsible for medication administration, on 07/24/10 (evening shift). She stated the resident took the medications with water at 8:00 PM. LPN #2 stated she was not aware of any medications left at the resident's bedside. An interview with RN #2, on 07/27/10 at 3:35 PM, revealed she worked the day shift, on 07/25/10. She went to the resident's room with the intention of giving the resident his/her morning medications and found the resident extremely drowsy and the resident would not arouse to take the medications. She assessed the resident and sent the resident to the hospital, per physician's orders. The medications that were not taken by the resident were destroyed. She stated she was not aware of any medications left at the bedside. An observation, on 07/29/10 at 4:10 PM, revealed Resident #15 had returned to the facility from the hospital and was in bed. An interview with Resident #15, on 07/29/10 at 7:25 PM, revealed he/she could not remember any medications left on the bedside table. Resident #15 stated, "I know my medications and usually take them without any problem." The resident stated medications had been left on the bedside table in the past, but had no recall of the identity of the staff responsible. An interview with the Assistant Director of Nursing (ADON), on 07/27/10 at 11:30 AM, revealed he did not know why the medications would have been left at the bedside or who would have left them. The resident was sent out to the hospital on 07/25/10 during the morning, due to a mental	F 323			

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F 323	Continued From page 18 status change. The medications left on the bedside table was probably the 07/24/10 evening medications. An interview with the Director of Nursing (DON), on 07/29/10 at 10:00 AM, revealed upon discovery of the medications at the bedside, the resident's physician and the Medical Director were notified. She completed random medication audits and follow-ups. A review of the facility's policy/procedure, "Administration of Oral (PO) Medication," dated 08/22/08 revealed, "Have resident take medications orally followed by a recommended five ounces of water. Remain with the resident until the medication has been swallowed. If the resident is uncooperative, do not hesitate to check his/her mouth and cheeks to assure that the medication has been swallowed. Medications cups and disposable accessories must be disposed of in the trash receptacle on the medication cart, not in a resident's trash can. Record administration on the MAR. It should not be recorded that the drug was administered unless the staff person is positive that the resident has indeed swallowed the entire dose of medication."	F 323			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record	F 332	Resident #20, #21, #22 will receive medications that are in accordance with physicians' orders. These services will be provided and meet professional standards of quality. The Director of Nurses upon notification during the survey process of the medication error, immediately counseled the KMAs involved in providing medications		

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F 332	<p>Continued From page 19</p> <p>reviews, it was determined the facility failed to ensure that it was free of medication error rates of five percent or greater. Observations during three medication passes revealed there were three errors in 41 opportunities, resulting in a seven percent medication error rate for three residents not in the selected sample of 19 (#20, #21, and #22). Findings include:</p> <p>1. A review of the physician's orders and the Medication Administration Record (MAR), dated 07/01/10 to 07/31/10, revealed Metformin 500 mg was ordered for Resident #20 and scheduled for 8:00 AM and 5:00 PM.</p> <p>Observation during the medication pass, on 07/27/10 at 2:57 PM, revealed Kentucky Medication Aide (KMA) #1 administered the Metformin 500 mg to Resident #20.</p> <p>An Interview with KMA #1, on 07/29/10 at 11:30 AM, revealed she had an hour before or after to administer the medication. She stated she did not think she had given the medication outside of the time frame, until the Director of Nursing (DON) mentioned it to her. KMA #1 stated, "I realize I had given the resident the medication too early. I just got in a hurry".</p> <p>2. A review of the physician's orders and the MAR, dated 07/01/10 to 07/31/10, revealed Resident #21 had orders for Metformin 500 mg tab, to be administrated at 8:00 AM, at 12:00 Noon, and at 5:00 PM, with meals/take with food.</p> <p>An observation during a medication pass, on 07/27/10 at 3:15 PM, revealed KMA #2 administered the Metformin 500 mg tab.</p>	F 332	<p>outside of the accepted timeframe for residents #20, #21 and #22.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Those staff members who administer medications were re-educated regarding professional standard and facility policy of providing medications on Thursday, August 19, 2010. Those employees not attending the in-service, received make-up in-services on or before Saturday, August 28, 2010. Upon receipt of this statement of deficiencies employees were re-educated prior to their next scheduled shift.</p> <p>In regards to the administration of oral medications the Quality Assurance Nurse will complete five medication administration audits per week times four weeks. Each week five medications will be observed during the course of the audit. The results of these audits will be presented to the Director of Nurses. If non-compliance is identified disciplinary action will be taken. Once the deficient practice has been</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2010
NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
(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	
F 332	<p>Continued From page 20</p> <p>3. Observation of a medication pass on 07/27/10 at 3:19 PM for Resident #22 revealed KMA #2 administered one Metformin 500 mg tab.</p> <p>Reviews of the physician's orders and the MAR, dated 07/01/10 to 07/31/10, revealed the resident had an order for Metformin 500 mg to be administered at 8:00 AM and at 5:00 PM.</p> <p>An interview with KMA #2, on 07/27/10 at 6:05 PM, revealed he had an hour before or after to administer the medications to the residents. He stated he was aware the Metformin was ordered at 5:00 PM, but he administered it early so that he could keep up with the other duties he had.</p> <p>An interview, on 07/27/10 at 6:15 PM, with Registered Nurse (RN) #3 revealed staff members have an hour before or after to administer medication. He stated the 5:00 PM time for the medication was in the middle of evening dining. "Everybody knows twice daily is 8:00 AM and 8:00 PM. We can adjust the medication times to fit the resident, but the KMAs should be giving the medication within the time frame."</p> <p>An interview, on 07/29/10 at 10:15 AM, with the Director of Nursing revealed she had reminded the staff members that they had an hour before or after to administer the medications. She revealed none of the supervisors on the floor had reported any problems with medications not being given within the time frame. She stated the medication policy stated staff members could exceed the hour time but not give the medicine before. The DON stated, "I don't want them to go past the hour before or after to give the medication".</p>	F 332	resolved the audits will continue at a rate of ten per month including ten different residents with a minimum of five different employees. The results of these audits will be presented during the Quarterly Quality Assurance meeting.	08/29/2010	

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NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
(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	
F 332	Continued From page 21 An interview with the pharmacist, on 07/29/10 at 11:28 PM, revealed administration of the medication outside the time frame regularly might cause the blood sugar to go a little lower and multiple dosing of the medication increases the risk for drops in a resident's blood sugar. The pharmacist stated the medication should be given as ordered within the established time frame. An interview, on 07/29/10 at 12:21 PM, with the physician revealed it was not a good practice to give the medication early. He stated he preferred the medication be given within the time constraints of the program.	F 332			
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure staff members washed their hands or changed gloves after direct contact with each resident. Observations on 07/28/10 and 07/29/10 revealed staff were not washing their hand and/or changing their gloves after contact with five residents (#1, #2, #3, #9, and #13), in the selected sample of 19. Findings include: 1. A record review revealed Resident #3 was admitted to the facility on 10/19/09 with diagnoses to include Urinary Tract Infection, Septic Shock,	F 444	Residents #1, #2, #3, #9 and #13 will receive proper hand washing technique provided by staff to prevent the spread of infection. One SRNA is no longer employed with this facility. The other SRNA who was identified during the survey was counseled regarding the correct procedure handwashing techniques for resident #9 and #13 by the Director of Nurses on July 29, 2010. All other employees were re-educated during the staff in-service of make-up in-services. All residents have the potential to be affected by this deficient practice. All staff have been re-educated regarding preventing the spread of		

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F 444	<p>Continued From page 22</p> <p>Grand Mal Seizures, Hypotension, Acute Renal Insufficiency, Severe Coagulopathy and Anemia.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/25/10, revealed the resident was assessed as requiring total assistance with all activities of daily living (ADLs). Further review revealed the resident had a Stage 2 pressure sore and was incontinent of bowel and bladder.</p> <p>An observation, on 07/28/10 at 2:15 PM, revealed Licensed Practical Nurse (LPN) #3 completed a treatment of a Stage 2 pressure sore on Resident #3's coccyx area. During the procedure, LPN #3 touched the inside of the dressing, with her gloved hand, prior to applying the dressing to the pressure sore.</p> <p>An interview with LPN #3, on 07/28/10 at 5:45 PM revealed, she did not realize she touched the inside of the dressing prior to the application; however, she did realize that this was improper technique.</p> <p>Additionally, an observation on 07/28/10 at 2:30 PM revealed, State Registered Nurse Aldes (SRNA) #1 and #2 provided appropriate incontinent care for Resident #3; however, afterward each of the SRNAs touched various items near the resident's bed, such as the bedside table and the siderail or their own clothing without changing gloves. SRNA #2 stuck wipes back in the container after touching them with her dirty gloves.</p> <p>Interviews with SRNAs #1 and #2, on 07/30/10 at 1:55 PM and at 2:00 PM, revealed they did not realize their errors at the time, but would be more</p>	F 444	<p>infection as related to staff washing their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>The Staff Development Coordinator will monitor nursing staff providing catheter care to ensure proper hand washing after each direct resident contact for which hand washing is indicated by accepted professional practice to all residents who have a catheter twice weekly times four weeks.</p> <p>The Staff Development Coordinator will monitor nursing staff providing incontinent care for ten residents per week times four weeks to ensure proper hand washing after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>The results of the audits pertaining to catheter and incontinent care will be reviewed by the Director of Nurses. Once the deficient practice have been resolved the audits will continue at a rate of ten residents per month with a minimum of two of the</p>		

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NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
(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	
F 444	<p>Continued From page 23 aware in the future.</p> <p>A review of the facility's policy/procedure, "Aseptic Technique" dated 08/05 revealed, "Utilization of clean technique within this facility may include but is not limited to dressing changes, where sterile technique is not ordered or required, care and treatment procedures such as tube feeding, oral care, skin care, etc., and cleaning of the environment."</p> <p>2. A record review revealed Resident #13 was admitted to the facility on 03/13/08 with diagnoses to include Neurogenic Bladder with spasms, Urinary Retention, Multiple Sclerosis (Mid-Late Stage), Renal Insufficiency, and Urinary Tract Infection with Pseudomonas.</p> <p>A review of the quarterly MDS, dated 06/23/10, revealed the facility failed to be moderately impaired with decision making and required total assistance with two people with all ADLs. Resident #13 had an indwelling catheter and was incontinent of bowel.</p> <p>An observation, on 07/29/10 at 2:10 PM, revealed SRNA #4 provided incontinent care for Resident #13. Upon entering the room, SRNAs #3 and #4 did not wash their hands prior to donning gloves. The resident had a large amount of very loose stool on the bed, gown, sheets and bedspread. SRNA #3 was observed touching soiled linens with gloved hands and placing the linens into a clear plastic bag. SRNA #3 proceeded to handle clean linens with the soiled gloves in place. SRNAs #3 and #4 were observed providing incontinent care to the resident with the same gloves that were covered with a very large amount of stool. SRNA #4 took a peri-wipe and</p>	F 444	<p>residents have catheters. The results of these audits will be presented during the Quarterly Quality Assurance meeting.</p> <p>The Director of Nurses will monitor the treatment nurse complete a treatment to a wound twice weekly times four weeks to ensure proper technique. If non-compliance is identified, education will occur immediately. In the event continued non-compliance disciplinary action will occur. Once the deficient practice has been resolved the audit will continue at a rate of one weekly. The results of these audits will be presented during the Quarterly Quality Assurance meeting.</p>	08/29/2010	

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NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF BENTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025
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F 444	<p>Continued From page 24</p> <p>wiped stool off SRNA #3's glove and continued providing incontinent care. SRNA #3 touched the resident's catheter tubing with soiled gloves several times during care. SRNA #4 provided catheter care but was seen wiping the catheter tubing repeatedly with the same peri-wipe.</p> <p>3. A record review revealed Resident #1 was admitted to the facility with diagnoses to include Left Hip Surgery, Osteopenia, Dementia, Osteoarthritis and Hallucinations.</p> <p>A review of the quarterly MDS assessment, dated 05/28/10, revealed Resident #1 was severely cognitively impaired and required total assistance with two staff members with all ADLs. Further review revealed Resident #1 was incontinent of bowel and bladder.</p> <p>An observation, on 07/29/10 at 2:30 PM, revealed SRNAs #3 and #4 provided incontinent care to Resident #1. SRNAs #3 and #4 did not wash their hands before or after providing care to the resident. Both SRNAs continued to wear gloves after providing care. They repeatedly touched the resident's wheelchair, curtain to the room, the door and SRNA #4's gait belt.</p> <p>4. A record review revealed Resident #2 was admitted to the facility with diagnoses to include Pain with generalized weakness, Dementia, Arthritis, Paranoid Confusion, and Dizziness.</p> <p>A review of the quarterly MDS, dated 07/19/10, revealed Resident #2 was assessed as moderately impaired with decision making and required extensive assistance with two staff members with all ADLs. Further review revealed the resident was incontinent of bowel and</p>	F 444		
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NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 841 SOUTH BENTON, KY 42025		
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F 444	<p>Continued From page 25 bladder.</p> <p>An observation, on 07/29/10 at 2:38 PM, revealed SRNAs #3 and #4 did not wash their hands before or after providing incontinent care for Resident #2.</p> <p>5. A record review revealed Resident #9 was admitted to the facility with diagnoses to include Pyelonephritis, Nephrolithiasis, Benign Prostatic Hypertrophy (BPH), Urinary Retention, and Alzheimer's Dementia.</p> <p>A review of the quarterly MDS, dated 08/16/10, revealed the facility assessed Resident #9 was moderately impaired with decision making and requiring extensive assistance with all ADLs. Further review revealed the resident was incontinent of bowel and bladder.</p> <p>An observation, on 07/29/10 at 2:45 PM, revealed SRNAs #3 and #4 did not wash their hands before or after providing incontinent care to Resident #9. The resident also had a bowel movement while the SRNAs were providing incontinent care. SRNA #4 touched the catheter tubing three times with a soiled peri-wipe. Both of the SRNAs continued to wear soiled gloves while placing the catheter bag into a dignity bag, touching the wheelchair, and also the gait belt.</p> <p>Interviews with SRNAs #3 and SRNA #4, on 07/29/10 at 3:20 PM and at 3:35 PM, revealed neither SRNA realized they had not washed their hands before or after providing incontinent care to each of the residents.</p>	F 444			

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NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF BENTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 07/27/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Denise Thomas* TITLE *Administrator* (X6) DATE *8-20-10*

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.