

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



PRINTED: 03/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 02/23/2015
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NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 RICHMOND ROAD BEREA, KY 40403
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F 000	INITIAL COMMENTS An abbreviated standard survey (KY22802) was initiated on 02/19/15 and concluded on 02/23/15. The complaint was substantiated with deficient practice identified at "D" level.	F 000	Berea Health Care Center does not believe and does not admit that any deficiencies existed before, during or after the survey. Berea Health Care Center reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings or administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds. Nor is it meant to establish any standard of care, contractual obligation or position. Berea Health Care Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potential applicable peer review, quality assurance or self critical examination privileges which Berea Health Care Center does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Berea Health Care Center offers its responses, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	F 225 It is and was on the day of survey, the policy of Berea Health Care Center to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wanda Jones TITLE: Adm. (X6) DATE: 3-13-15

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 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility abuse policy it was determined the facility failed to ensure an allegation of abuse was reported immediately to the administrator and failed to protect other residents from potential abuse for one (1) of three (3) sampled residents (Resident #1). Resident #1 reported to a nurse and a State Registered Nurse Aide (SRNA) on 01/31/15 that another SRNA (SRNA #1) was rude and hateful toward the resident and had threatened to make the resident sit in a chair all night. The facility failed to report the allegation to the administrator immediately according to the facility policy. The facility further failed to report the allegation of abuse to required state agencies timely and failed to remove SRNA #1 from duty to protect other residents from abuse.</p> <p>The findings include:</p> <p>A review of the facility abuse policy titled "Resident Protection Policy," dated 08/01/13, revealed facility employees were required to report allegations of abuse immediately to the administrator. Further review of the policy revealed any employee observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the administrator. According to the policy, employees accused of abuse would be suspended</p>	F 225	<p>report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness of service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>It is and was on the day of survey, the policy of Berea Health Center to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>It is and was on the day of survey, the policy of Berea Health Care Center to have evidence that all alleged violations are thoroughly investigated, and to prevent further potential abuse while the investigation is in progress.</p> <p>It is and was on the day of survey, the policy of Berea Health Care Center that the results of all investigations be reported to the administrator or her designated representative and to other officials in accordance with State law (including the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action taken.</p> <p>1) On February 2, 2015, it was reported to the Administrator that Resident #1 had informed RN #1 (that was on duty on January 31, 2015) that SRNA #1 had</p>		

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F 225	<p>Continued From page 2</p> <p>immediately and the administrator or designee would promptly notify required state agencies of the allegation.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 01/21/15 with diagnoses that included History of Lung Cancer, Brain Tumor, Acute Renal Failure, and Congestive Obstructive Pulmonary Disease. Additional review of the record revealed the resident had a comprehensive Minimum Data Set (MDS) assessment dated 02/02/15 that revealed the resident was alert, oriented, and cognitively intact.</p> <p>An interview was conducted with Resident #1 on 02/23/15 at 10:30 AM. Resident #1 stated State Registered Nurse Aide (SRNA #1) assisted the resident to the bathroom and then to a recliner during the night on a date and time the resident could not recall. Resident #1 stated she was uncomfortable in the recliner and requested to go back to bed. In addition, Resident #1 stated SRNA #1 told the resident he/she could not go back to bed. Resident #1 stated he/she saw two staff members out in the hallway and asked if they would assist the resident back to bed. Further interview revealed while the two staff members were assisting Resident #1 to bed SRNA #1 came to the resident's doorway and said, "I see you got back in bed."</p> <p>An interview conducted with SRNA #2 on 02/23/15 at 3:40 PM revealed she and SRNA #3 were in the hallway near Residents #1's room on 01/31/15 at 2:00 AM when Resident #1 requested to go back to bed. According to SRNA #2, when she and SRNA #3 were assisting Resident #1 to bed, SRNA #1 came to Resident #1's door and</p>	F 225	<p>been rude and hateful to Resident #1. SRNA #1 had also threatened to make Resident #1 sit up in her chair all night. RN #1 had left the Director of Nursing a note alleging the abuse of Resident #1 by SRNA #1.</p> <p>Immediately after the administrator was informed of this by the Director of Nursing, an investigation was launched and SRNA #1 was suspended pending completion of the investigation.</p> <p>On February 5, 2015, SRNA #1's employment was terminated due to the outcome of the investigation.</p> <p>2) Other residents were interviewed by the Administrator and Director of Nursing to ensure that SRNA #1 (or any other staff member) had never been rude, hateful, or threatening to them.</p> <p>On admission, the Social Services Director provides all residents and/or their responsible parties with a copy of the Residents Rights, informing them of their right to be free from abuse while a resident at Berea Health Care Center. This information also educates them on the types of abuse and how and to whom to report an allegation of abuse.</p> <p>Upon hire, the Human Resources Assistant educates all staff regarding the facility's Abuse Policy.</p> <p>During the Resident Council Meetings, on a monthly basis, all attending residents will be re-educated by the Assistant Administrator regarding their right to be free from abuse, the types of</p>		

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F 225	<p>Continued From page 3</p> <p>said, "I see you got back in bed. It's just stupid you making us girls put you back in bed. I got you up and brushed your teeth for nothing." Further interview with SRNA #2 revealed Resident #1 reported to her that SRNA #1 had been "rude and hateful" to Resident #1 "all night." According to SRNA #2, she did not report the allegation at that time because she was afraid SRNA #1 would overhear her. Further interview revealed she did not report to the nurse on duty because she felt the nurse would not do anything about it even though the SRNA was aware that abuse was supposed to be reported immediately to the Nurse or the Director of Nursing and Administrator.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 02/23/15 at 2:10 PM, revealed RN #1 worked the day shift on 01/31/15. RN #1 stated that during rounds she asked Resident #1 if the resident was okay. Resident #1 reported to the RN she was "not okay" and "had a bad night." Further interview revealed Resident #1 reported to RN #1 that SRNA #1 assisted the resident to a chair and told the resident he/she would have to stay in the chair until morning. According to RN #1, she reported the allegation by leaving a note for the Director of Nursing regarding Resident #1's report even though RN#1 was aware of the facility abuse policy and was aware to report allegations immediately to the Director of Nursing and the Administrator.</p> <p>A review of the facility's investigation of the incident revealed the incident occurred on 01/31/15 at 2:00 AM. The allegation was not reported to the Administrator until 02/02/15 and SRNA #1 was not suspended until 02/02/15 when the Administrator and Director of Nursing became</p>	F 225	<p>abuse, and how to file a report if they feel that they have been abused.</p> <p>All staff, upon hire, will be educated regarding abuse, the types of abuse, and whom to report allegations of abuse to.</p> <p>All new department heads and charge nurses will be instructed by the Administrator and Director of Nursing to report allegations of abuse immediately to the appropriate people and agencies.</p> <p>3) All staff that failed to report this allegation timely and appropriately were immediately inserviced by the Director of Nursing regarding the facility's Abuse Policy and on immediate reporting of any allegations of abuse to the appropriate people and agencies.</p> <p>The Licensed Nurses attended a one and one-half hour inservice by Cooperate Consultant, Ruth Nelson, APRN on February 26, 2015 on Risk Management. Abuse, types of abuse, and timely reporting was also discussed.</p> <p>The Director of Nursing inserviced all staff on March 12, 2015. All staff were again inserviced regarding Berea Health Care Center's policy on abuse, types of abuse, and how and to whom to report any allegations of abuse.</p> <p>4) The Quality Assurance Nurse will interview ten staff members and/or residents monthly to ensure that all are aware of the facility's Abuse Policy, types of abuse, and how and to whom to report any allegations of abuse.</p>		

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F 225	Continued From page 4 aware of the allegation. An interview with the Director of Nursing (DON) on 02/23/15 at 4:30 PM, revealed the Director of Nursing arrived to work at the facility on 02/02/15 and found the note left by RN #1 reporting abuse of Resident #1. According to the Director of Nursing, she immediately informed the Administrator at that time and was directed to start an investigation. An interview with the Administrator on 02/23/15 at 4:45 PM revealed the DON made her aware of the allegation on 02/02/15. The Administrator stated SRNA #1 was suspended at that time and the required state agencies were notified of the allegation. According to the Administrator, the allegation was substantiated by the facility and the employee was terminated.	F 225	The facility will continue to educate new residents and responsible parties and new hires on abuse. 5) March 15, 2015.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility care plan policy it was determined the facility failed to provide services in accordance with the plan of care for one (1) of three (3) sampled residents (Resident #1). On 01/31/14 at approximately 1:30 AM, Resident #1 was assisted to ambulate to the bathroom by one staff person. A review of the plan of care for	F 282	F282 It is and was on the days of survey, the policy of Berea Health Care Center for services provided or arranged by the facility to be provided by qualified persons in accordance with each resident's written plan of care. 1) Resident #1's records were reviewed. The MDS record and ADL assessment indicated that Resident #1 was able to transfer and ambulate with the assistance of one staff. MDS staff had failed to update Resident #1's Nurse Aide Care Plan. Upon noting this discrepancy, the Care Plan was updated immediately to reflect Resident #1's care needs.		

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F 282	<p>Continued From page 5</p> <p>Resident #1 revealed the resident required the assistance of two staff persons for ambulation. The facility failed to assure staff provided the appropriate level of assistance to the resident according to the plan of care.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Nurse Aide Care Plan Kardex Protocol," (undated) revealed the Nurse Aide Care Plan Kardex will contain information on the level of assistance required by staff to provide the resident's activity of daily living, mobility, and toileting. Nurse Aides were responsible to view and utilize the Care Plan Kardex to have appropriate information needed to provide optimal care to residents.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 01/21/15 with diagnoses that included History of Lung Cancer, Brain Tumor, Acute Renal Failure, and Congestive Obstructive Pulmonary Disease. Additional review of the record revealed the resident had a comprehensive Minimum Data Set (MDS) assessment dated 02/02/15 that revealed the resident was alert, oriented, and cognitively intact. The medical record further revealed the Care Plan Kardex was initiated on 01/22/15. The Care Plan Kardex stated Resident #1 required the assistance of two staff persons for transfers and ambulation.</p> <p>An interview conducted with Resident #1 on 02/23/15 at 10:30 AM, revealed the resident was assisted with transfers and ambulation by one staff person, but did not remember the date or time this occurred.</p>	F 282	<p>2) The Charge Nurses reviewed all residents' Nurse Aide Care Plans to ensure that each resident's needed amount of assistance was reflected on each individual Nurse Aide Care Plan.</p> <p>3) During each weekly Care Plan Conference, the Unit Coordinators will review, with other disciplines, each Nurse Aide Care Plan to ensure that all residents are receiving the assistance and care to meet their individual needs.</p> <p>4) On a monthly basis for six months, the Quality Assurance Nurse will review ten residents' Nurse Aide Care Plans and MDSs to ensure that the assistance that each resident needs per the MDS is noted on the Nurse Aide Care Plan and is being provided.</p> <p>5) March 12, 2015.</p>		

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F 282	<p>Continued From page 6</p> <p>Interview conducted with State Registered Nurse Aide (SRNA) #1 on 02/23/15 at 1:45 PM, revealed Resident #1 requested to go to the bathroom on 01/31/15 at approximately 1:30 AM. According to SRNA #1, she transferred and assisted Resident #1 from the bed to the bathroom and then assisted the resident to a recliner after the resident was finished using the bathroom by herself without the assistance of another staff person. SRNA #1 stated she thought the resident only required the assistance of one staff person and was not aware the resident required the assistance of two for transfers and ambulation even though SRNA #1 had signed the resident's Kardex for 01/31/15 acknowledging that she had provided care in accordance with the Kardex.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 02/23/15 at 2:00 PM, revealed the LPN was the nurse assigned to Resident #1 on 01/31/15 from 11:00 PM to 7:00 AM and was not aware SRNA#1 did not provide care in accordance with the plan of care. Further interview revealed the LPN made rounds three to four times per shift to ensure care was provided in accordance with the plan of care and had not identified any concerns.</p> <p>An interview was conducted with the Director of Nursing on 02/23/15 at 4:30 PM. The DON revealed the SRNAs were to review the Care Plan Kardex each shift and sign to acknowledge they were aware of the Care Plan and provided care according to the Care Plan Kardex. Further interview revealed the DON made daily rounds to ensure care was provided as planned. According to the DON, she was not aware SRNA #1 had not followed the plan of care when assisting Resident</p>	F 282			

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F 282	Continued From page 7 #1 on 01/31/15.	F 282			