



PRINTED: 07/17/2015
FORM APPROVED
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: 185103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/02/2015
NAME OF PROVIDER OR SUPPLIER THE TERRACE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1043 BROOKLYN BOULEVARD BEREA, KY 40403	
(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 000	INITIAL COMMENTS A standard health survey was conducted on 06/30/15 through 07/02/15. Deficient practice was identified with the highest scope and severity at "D" level. An abbreviated standard survey (KY23455) was also conducted at this time. The complaint was unsubstantiated with no deficient practice related to the allegation.	F 000	The Terrace Nursing and Rehabilitation Facility does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Terrace reserves the right to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any 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, is not meant to establish any standard of care, contract obligation or position. The Terrace 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 potentially applicable peer review, quality assurance or self examination privileges which The Terrace does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Terrace offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to our residents.	
F 248 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure one (1) of twenty (20) sampled residents (Resident #1) received services with reasonable accommodations for individual needs. Observation on 06/30/15 during the evening meal revealed Resident #1's meal tray was served on the overbed table; however, the table was too high for the resident to see the food on the tray and the resident had difficulty feeding himself/herself. The findings include:	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Paula Long - Shank

TITLE

Administrator

(X6) DATE

7/24/15

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 246	Continued From page 1 Interview with Director of Nursing (DON) on 07/01/15 at 3:15 PM revealed there was no policy pertaining to meal tray setup. Medical record review for Resident #1 revealed the facility admitted the resident on 08/04/14 with diagnoses that included Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Hyperlipidemia, Renal Artery Stenosis with stent placement, Dementia, and Benign Prostatic Hyperplasia. Review of the annual Minimum Data Set (MDS) assessment dated 06/22/15 revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be 9, indicating the resident had moderate cognitive impairment. Further review of the MDS revealed the facility assessed the resident to require extensive assistance with all ADLs except eating, in which the resident was independent requiring assistance with setup only. Observation on 06/30/15 at 5:20 PM revealed student Nurse Aide (NA) #7 carried Resident #1's dinner tray to his/her room, set it up on the overbed table, and raised the head of the bed for Resident #1 to a 45-degree angle. Resident #1 had a wedge between his/her knees that caused the knees to be elevated off the bed. NA #7 positioned the overbed table above Resident #1's knees and lowered it as far as it would go. The table was positioned right above the resident's knees with the overbed table at eye level with Resident #1. The privacy curtain was pulled between Resident #1 and his/her roommate, and Certified Nursing Assistant (CNA) #4 was feeding Resident #1's roommate. Observations further revealed Resident #1 attempted to feed himself/herself, but had difficulty reaching the	F 246	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES It is the policy of The Terrace Nursing and Rehabilitation Facility that a resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Resident #1 is alert and oriented to his/her person, place and time of day. Resident is able to express self and make needs known. Resident #1 eats in bed per own request. Resident #1 feeds self meals and refuses help from staff other than for meal tray set up. Resident #1 is able to physically move over bed table by self to suit self. Resident #1 has attention seeking behavior related to care and meals and it is so documented. Resident #1 weight is stable without a significant weight loss. 1. Resident #1 was offered and then repositioned in bed for the meal. 2. July 6 th through July 23 rd an audit was done by the Director of Nursing, the RN unit coordinator or the RN weekend house supervisor to assure residents that need assistance in meal positioning were positioned according to each individual needs. No discrepancies or concerns were identified.		

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F 246	<p>Continued From page 2</p> <p>food and did not eat anything from the tray.</p> <p>Interview with Resident #1 on 06/30/15 at 5:25 PM revealed staff set his/her tray up high "all the time." Resident #1 stated if the staff would help him/her eat, he thought he/she would eat more. Resident #1 stated he/she could not see or reach all of the food on the tray due to the table being so high.</p> <p>Interview with NA #7 on 07/02/15 at 3:25 PM revealed she served Resident #1 the evening meal tray on 06/30/15 and thought the resident would probably have had difficulty reaching all of the food. NA #7 stated she should have gotten a Certified Nurse Aide to assist in repositioning Resident #1 in bed more. NA #7 said she was a student nurse aide and that a Certified Nurse Aide was supposed to supervise her at all times. NA #7 stated the CNA that was supervising her that day was feeding Resident #1's roommate during the evening meal service.</p> <p>Interview with CNA #4 on 07/02/15 at 2:45 PM revealed the over bed table should have been lower for Resident #1 to easily reach and see the food. CNA #4 further stated that she did not check on NA #7 to make sure the tray was set up correctly, but that a CNA should have since NA #7 was a student.</p> <p>Interview with Registered Nurse (RN) #2 on 07/02/15 at 3:00 PM revealed she was the nurse assigned to Resident #1 during the evening meal on 06/30/15. RN #2 stated the overbed table should have been lower so that Resident #1 could reach the food better. RN #2 stated a CNA should have been supervising NA #7 when setting up trays.</p>	F 246	<ol style="list-style-type: none"> 3. On June 30th and July 3rd nurses and nurse aides were in-serviced by the Director of Nursing or the QA Nurse on positioning of residents for meals. 4. On July 6th a weekly audit was implemented by the Director of Nursing to monitor resident meal tray positioning/set up. The audit will be done weekly and continue for three months. If no discrepancies or concerns are identified then the audit will then be done monthly. 5. Corrective actions were completed on, July 24, 2015. 	07/24/15	

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F 246	Continued From page 3	F 246		
F 282 SS=D	<p>Interview with the Director of Nursing (DON) on 07/01/15 at 3:15 PM revealed that Resident #1's overbed table "probably should not have been that high" and that somebody should have been looking at NA #7's work.</p> <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, interview, record review, and facility policy review it was determined the facility failed to provide care in accordance with the Comprehensive Plan of Care for one (1) of twenty (20) sampled residents (Resident #9). Resident #9's Comprehensive Care Plan contained care plan interventions that included oxygen as ordered; however, observations on 08/30/15 and 07/01/15 revealed oxygen was not in use for Resident #9.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Using the Care Plan," dated 08/01/13, revealed daily care and documentation must be consistent with the resident's care plan. Further review revealed changes in the resident's condition must be reported to the Nurse Assessment Coordinator so that a review of the resident's assessment and care plans can be made.</p>	F 282	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>It is the policy of The Terrace Nursing and Rehabilitation Facility that 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>Resident #9 has a medical diagnosis of Severe Alzheimer's Type Dementia. Resident #9 is independent in wheelchair mobility. Resident #9 exercises rights to remove oxygen cannula at will. Resident #9 is able to apply and remove oxygen cannula independently. Resident #9 has experienced no respiratory distress from removing the oxygen cannula PRN. Ongoing monitoring of resident's O2 Sat during June 30th - July 2nd was at 98% at room air. Resident #9 has overall noncompliance with care identified on the care plan.</p>	

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F 282	<p>Continued From page 4</p> <p>Review of Resident #9's medical record revealed the facility admitted Resident #9 on 06/17/14 with diagnoses of Severe Alzheimer's Disease, Hypertension, Muscle Weakness, Osteoarthritis, and Cardiovascular Disease. Review of the Minimum Data Set (MDS) dated 05/08/15 revealed Resident #9 was unable to be interviewed due to being severely cognitively impaired. Further review of the MDS revealed Resident #9 required the use of oxygen.</p> <p>Review of the Comprehensive Care Plan, updated on 06/12/15, revealed Resident #9 was at risk for altered cardiac output and required the use of oxygen. Review of the physician orders revealed oxygen was to be administered at 2 liters per minute (LPM) via nasal cannula.</p> <p>Observations of Resident #9 on 06/30/15 at 11:20 AM, 3:05 PM, 4:05 PM, and 5:45 PM, and 07/01/15 at 8:55 AM, 10:10 AM, and 10:55 AM, revealed Resident #9 was sitting in a wheelchair in different areas of the facility without oxygen in use by the resident.</p> <p>Interview with Unit Coordinator #1 on 07/02/15 at 1:40 PM revealed she was responsible for updating the care plans when new orders were written. She further revealed staff does QA (Quality Assurance) on oxygen when a resident has an order for oxygen weekly. No problems had been identified with staff not following the care plans and providing oxygen for residents.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 07/02/15 at 1:50 PM revealed she had noticed Resident #9 had not been wearing his/her oxygen but had assumed the oxygen was ordered on an</p>	F 282	<ol style="list-style-type: none"> 1. Resident #9 assessed for signs/symptoms of respiratory distress. Negative for any signs/symptoms for respiratory distress. O2 Sat checked and found to be normal at 98% on room air. Physician called and order received to change oxygen order to PRN. 2. On July 7th or 8th all residents with oxygen orders were audited by the Director of Nursing and/or the RN unit coordinators to assure the oxygen order matched the care plan and matched resident compliance with the order. No discrepancies or concerns were found. 3. On July 3rd nurses and nurse aides were in-serviced by the Director of Nursing on the need to assure residents are utilizing their oxygen as ordered by their physician. Physician orders and resident care plans will be updated by the nurse to reflect resident's current needs. 4. On July 7th an Oxygen Audit was implemented by the Director of Nursing to assure residents' oxygen orders matched the care plans and matched resident compliance with the orders. The audit will be conducted twice weekly for three months. If no discrepancies or concerns are identified 	

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F 282	Continued From page 5 as needed basis. She further stated she had not seen Resident #9 in any respiratory distress. Interview with the MDS Coordinator on 07/02/15 at 2:00 PM revealed she was responsible for developing the care plans and updating the care plans as needed. However, she was not responsible for ensuring staff followed the care plans. Interview with the Director of Nursing (DON) on 07/02/15 at 3:45 PM revealed staff has morning meetings to discuss new orders and to update the care plans. She further stated no problems had been identified concerning following the care plans.	F 282	then the audit will then be conducted monthly. 5. Corrective actions were completed on July 8, 2015.	7/08/15	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure one (1) of twenty (20) sampled residents (Resident #9) received oxygen	F 328	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS It is the policy of The Terrace Nursing and Rehabilitation Facility that the facility ensures that residents receive proper treatment and care for the following special services: Respiratory care Resident #9 has a medical diagnosis of Severe Alzheimer's Type Dementia. Resident #9 is independent in wheelchair mobility. Resident #9 exercises rights to remove oxygen cannula at will. Resident #9 is able to apply and remove oxygen cannula independently. Resident #9 has experienced no respiratory distress from removing the oxygen cannula PRN. Ongoing monitoring of resident's O2 Sat during June 30 th – July 2 nd was at 98% at room air. Resident #9 has overall noncompliance with care identified on the care plan.		

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F 328	<p>Continued From page 6</p> <p>therapy according to physician orders and the plan of care. Resident #9 had physician's orders and care plan interventions for oxygen at 2 liters per minute (LPM). However, during several observations on 06/30/15 and 07/01/15, Resident #9 was out of his/her room, without oxygen being administered.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 07/02/15 at 3:45 PM revealed the facility did not have a policy concerning the use of oxygen.</p> <p>Review of Resident #9's medical record revealed the facility admitted Resident #9 on 06/17/14 with diagnoses of Severe Alzheimer's Disease, Hypertension, Muscle Weakness, Osteoarthritis, and Cardiovascular Disease. Review of the Minimum Data Set (MDS) dated 05/08/15 revealed Resident #9 was unable to be interviewed due to severe cognitive impairment. Further review of the MDS revealed Resident #9 required the use of oxygen.</p> <p>Review of the Comprehensive Care Plan, updated on 06/12/15, revealed Resident #9 was at risk for altered cardiac output and had interventions for the use of oxygen. Review of the physician's orders dated 02/25/15 revealed Resident #9 was to have oxygen at 2 liters per minute (LPM) via nasal cannula to maintain oxygen saturation levels above 90 percent. Review of the oxygen saturation levels that were performed monthly, revealed Resident #9's oxygen saturation level was maintained above 90 percent as ordered.</p> <p>Observations of Resident #9 on 06/30/15 at 11:20</p>	F 328	<ol style="list-style-type: none"> 1. Resident #9 assessed for signs/symptoms of respiratory distress. Negative for any signs/symptoms for respiratory distress. O2 Sat checked and found to be normal at 98% on room air. Physician called and order received to change oxygen order to PRN. 2. On July 7th or 8th all residents with oxygen orders were audited by the Director of Nursing and/or the RN unit coordinators to assure the oxygen order matched the care plan and matched resident compliance with the order. No discrepancies or concerns were found. 3. On July 3rd nurses and nurse aides were in-serviced by the Director of Nursing on the need to assure residents are utilizing their oxygen as ordered by their physician. Physician orders and resident care plans will be updated by the nurse to reflect resident's current needs. 4. On July 7th an Oxygen Audit was implemented by the Director of Nursing to assure residents' oxygen orders matched the care plans and matched resident compliance with the orders. The audit will be conducted twice 		

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F 328	Continued From page 7 AM, 3:05 PM, 4:05 PM, and 5:45 PM, and 07/01/15 at 8:55 AM, 10:10 AM, and 10:55 AM) revealed Resident #9 was sitting in a wheelchair in different areas of the facility without receiving oxygen. Interview with Unit Coordinator #1 on 07/02/15 at 1:40 PM revealed she had noticed Resident #9 without the oxygen on while in the wheelchair, but assumed the oxygen was ordered as needed. She further revealed no problems had been identified with residents not receiving oxygen as ordered. Interview with Licensed Practical Nurse (LPN) #1 on 07/02/15 at 1:50 PM revealed she had noticed Resident #9 had not been wearing his/her oxygen but had assumed the oxygen was ordered on an as needed basis. She further stated she had not seen Resident #9 in any respiratory distress. Interview with the Director of Nursing (DON) on 07/02/15 at 3:45 PM revealed staff had morning meetings to discuss new orders and to update the care plans. She further stated no problems had been identified concerning residents receiving oxygen as ordered.	F 328	weekly for three months. If no discrepancies or concerns are identified then the audit will then be conducted monthly. 5. Corrective actions were completed on July 8, 2015.	7/08/15	
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 366	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE It is the policy of The Terrace Nursing and Rehabilitation Facility that each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.		

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F 366	<p>Continued From page 8</p> <p>and facility policy review, it was determined the facility failed to ensure residents' food preferences were honored for residents that had identified food dislikes for one (1) of twenty (20) sampled residents (Resident #1). Resident #1 disliked cheese; however, on 06/30/15 during the 2:00 PM snack service, Resident #1 was observed to have a bologna and cheese sandwich.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Food Preference/Diet History Record," dated 2013, revealed upon a resident's admission to the facility, the Dietary Manager (DM) would identify a resident's food preferences, food likes, and food dislikes. The policy stated, "Obtained information should be used to develop client tray cards for meal service and should be updated as necessary."</p> <p>Review of Resident #1's meal tray card revealed that one of the resident's dislikes was cheese.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 08/04/14 with diagnoses that included Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Hyperlipidemia, Renal Artery Stenosis with stent placement, Dementia, and Benign Prostatic Hyperplasia. Further review of the record revealed a Minimum Data Set (MDS) Assessment with a reference date of 06/22/15. The MDS revealed the resident was interviewable with a Brief Interview for Mental Status (BIMS) score of 9.</p> <p>Observation of Resident #1 on 06/30/15 at 2:30</p>	F 366	<p>Resident #1 is alert and oriented to his/her person, place and time of day. Resident is able to express self and make needs known. Resident #1 has a medical diagnosis of Dementia and has attention seeking behavior related to care and meals and it is so documented. Resident #1 weight is stable, without a significant weight loss. Resident #1 currently has over 20 food items on his/her dislike list. The list is updated as frequent as daily by the Director of Dietary because of resident changing mind about what he/she does and doesn't like to eat.</p> <ol style="list-style-type: none"> 1. Resident #1 removed cheese from sandwich per self and ate the sandwich. Another sandwich was offered. Resident refused any additional snack. 2. On July 7th an audit was conducted by the Director of Dietary of all resident meal trays and preferences to assure all residents were receiving their food preferences and not any food dislikes. No discrepancies or concerns were identified. 3. On June 30th nurses and nurse aides were in-serviced by the Director of Nursing on food preferences. On July 2nd all dietary staff was in-serviced by the Director of Dietary on food preferences and meal tray/snack accuracy to tray card preferences. 		

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NAME OF PROVIDER OR SUPPLIER THE TERRACE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1043 BROOKLYN BOULEVARD BEREA, KY 40403		
(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 366	Continued From page 9 PM revealed Resident #1 received a bologna and cheese sandwich for a 2:00 PM snack. The sandwich was lying on the overbed table unopened. Interview conducted with Resident #1 on 06/30/15 at 2:30 PM revealed, "I do not like cheese." Resident #1 stated he/she had informed staff several times of the dislike, but stated staff continued to send cheese. Interview conducted with the Dietary Manager (DM) on 07/02/15 at 3:35 PM, revealed Resident #1 should not have received a bologna sandwich with cheese on it. Interview conducted with the Registered Dietitian (RD) on 07/02/15 at 3:45 PM revealed that the resident had many dislikes and was very hard to please. The RD stated the resident should not have received a bologna sandwich with cheese due to the resident's dislike of cheese.	F 366	4. Beginning July 6 th an audit was implemented by the Director of Dietary to monitor meal tray/snack accuracy to tray card preferences. The audit will be conducted weekly for three months. If no discrepancies or concerns are identified the audit will be conducted monthly. 5. Corrective actions were completed on July 8, 2015.	7/08/15	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS It is the policy of The Terrace Nursing and Rehabilitation Facility to 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. The nurse performing the cleansing of the blood glucose monitoring device did wash her hands and apply gloves before performing the cleaning. The cleaning was done with a bleach wipe. The nurses' gloves were sanitized with bleach.		

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F 441	<p>Continued From page 10</p> <p>(3) Maintains a record of incidents and corrective 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, interview, and facility policy review, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for two (2) unsampled residents (Residents B and C) of twenty (20) sampled and three (3) unsampled residents. Observation during medication administration/blood glucose monitoring on 07/02/15, revealed staff failed to change their</p>	F 441	<ol style="list-style-type: none"> Residents affected were assessed by a RN for signs and symptoms of infection. No infections/adverse affects were noted. Their assessments were documented in their charts. July 3rd through July 23rd audits were performed by the Director of Nursing to assure nurses performing blood glucose monitoring were properly washing/sanitizing hands and changing gloves. No discrepancies or concerns were identified. On July 3rd the Director of Nursing and the QA Nurse in-serviced nurses on proper blood glucose monitoring device sanitation and proper hand washing/sanitizing and glove changes. Return demonstration was performed by nurses. On July 6th an audit for proper blood glucose monitoring device use including handwashing/sanitizing and glove changes was implemented by the Director of Nursing and QA Nurse. The audit will be conducted weekly for three months. If no discrepancies or concerns are identified the audit will be conducted monthly. Corrective actions were completed on July 24, 2015. 	7/24/15	

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F 441	<p>Continued From page 11</p> <p>gloves and wash/sanitize their hands after cleansing the blood glucose monitoring device, and proceeded to perform blood glucose monitoring for Resident B and Resident C.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Cleaning Your Meter," undated, revealed the policy did not address wearing gloves or hand washing while disinfecting the blood glucose monitoring device.</p> <p>Review of the facility's policy titled "Hand Hygiene," undated, revealed staff was required to wash/sanitize their hands before any invasive procedure.</p> <p>Observation of Licensed Practical Nurse (LPN) #3 on 07/02/15 at 11:15 AM revealed the LPN washed/sanitized her hands, applied gloves, and then cleaned the blood glucose monitoring device with a bleach wipe. LPN #3 proceeded to perform blood glucose monitoring for Resident B without changing gloves or washing/sanitizing her hands. The LPN then cleaned the blood glucose monitoring device without changing gloves or washing/sanitizing her hands.</p> <p>Observation of LPN #3 on 07/02/15 at 11:30 AM revealed LPN #3 washed/sanitized her hands, applied gloves, and performed blood glucose monitoring for Resident C. The LPN then cleansed the blood glucose monitoring device without changing her gloves or washing/sanitizing her hands. The LPN was observed to discard her gloves and wash/sanitize her hands after the device was cleansed.</p> <p>Interview conducted with LPN #3 on 07/02/15 at</p>	F 441		

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F 441	<p>Continued From page 12</p> <p>11:40 AM, revealed she was aware she should have changed her gloves and washed/sanitized her hands prior to cleansing the blood glucose monitoring device and after performing blood glucose testing. The LPN stated she had attended in-services by the facility on blood glucose testing and cleansing of the blood glucose monitoring device, but was nervous and forgot to change gloves and wash her hands.</p> <p>Interview conducted with the Director of Nursing (DON) on 07/02/15 at 2:50 PM revealed she made rounds several times throughout the day to ensure residents were being provided the care they required. The DON stated she attended morning meeting where resident care was discussed. The DON stated random medication administration observations, which included blood glucose monitoring, were completed, and no concerns had been identified regarding blood glucose monitoring. The DON stated staff was required to change gloves and wash/sanitize their hands after cleansing a blood glucose monitoring device, and after performing blood glucose testing.</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2015
NAME OF PROVIDER OR SUPPLIER THE TERRACE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1043 BROOKLYN BOULEVARD BEREA, KY 40403	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2003</p> <p>SURVEY UNDER: 2000 Existing (Short Form)</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (111)</p> <p>SMOKE COMPARTMENTS: 3</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II Natural Gas generator</p> <p>A life safety code survey was initiated and concluded on 06/30/15, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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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