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

PRINTED: 03/09/2011
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
APR 4 2011
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C
	185384		02/23/2011

NAME OF PROVIDER OR SUPPLIER
BEREA HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
601 RICHMOND ROAD, PO BOX 49
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 survey was conducted on February 21-23, 2011. Deficient practice was identified with the highest scope and severity at "D" level. An abbreviated standard survey (KY15564) was also conducted at this time. The allegation was substantiated but no deficient practice was cited related to the allegation.	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 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.	F 157	**F 157** It is and was on the days of survey, the policy of Berea Health Care Center to notify the resident's physician when there is a significant change in	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Adm. 2-24-11

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	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to immediately inform the resident's physician when a change in the resident's condition occurred for one of eighteen sampled residents. Resident #8 had a diagnosis on September 17, 2010, of dehydration. Review of the resident's meal intake record revealed the resident failed to consume the recommended fluid requirements to maintain hydration for thirteen consecutive days in December 2010. There was no evidence the facility had identified the resident's poor fluid intake, and as a result the facility failed to notify the resident's physician when the change in condition occurred. (Refer to F280 and F327.) The findings include: A review of the facility's policy regarding changes in a resident's condition (dated January 9, 2003) revealed Nursing Services was required to notify the resident's attending physician when a significant change in the resident's physical, mental, emotional, or psychosocial status occurred. In addition, the policy noted the physician was required to be notified when a need to alter the resident's treatment significantly was indicated. The policy further noted the notification should be made as soon as practical, but should not exceed 24 hours, of a change in the resident's condition. Finally, the policy directed that all changes in the resident's condition must be	F 157	the resident's physical, mental or psychosocial status (i.e. deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). 1) Resident #8's intake and output is currently being monitored every shift and Hydration Assessments are being done weekly and as needed to ensure fluid needs are being met. If these needs are not met, the physician is notified by the charge nurse and notification is documented in Resident #8's clinical record. 2) All residents have been assessed to ensure adequate hydration. No residents were identified as being dehydrated. This assessment was conducted by the charge nurse of each unit. 3) The Director of Nursing will review residents' intake and output records and meal consumption records on a weekly basis to assist in assuring resident fluid needs are met and the physician is notified otherwise. All RNs and LPNs were inserviced on February 24, 2011 on Hydration Policy and Protocol. 4) As a part of the Quality Assurance Program, the Administrator and Clinical Team Leader will randomly	

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F 157	Continued From page 2 properly recorded in the resident's medical record. Resident #8 was admitted to the facility on May 19, 2008, with diagnoses including Parkinson's Disease, Hypertension, Congestive Heart Failure (CHF), Osteoporosis, Osteoarthritis, Angina, and Hyperlipidemia. A review of the Nutrition Care Progress notes conducted by the Registered Dietitian (RD) on May 21, 2010, revealed resident #8 had been assessed to require 1400-1700 cubic centimeters (cc) of fluids daily to maintain the resident's hydration status. A review of the physician's progress notes dated September 15, 2010, revealed the Nurse Practitioner (NP) assessed resident #8 due to mental status changes, a decrease in po intake, and abnormal lab test results. The progress notes stated the resident's BUN was 90 mg/dL (normal range 1-24 mg/dL), the Creatinine was 2.3 mg/dL (normal range 0.6-1.5 mg/dL), and the potassium level was 6.9 mEq/L (normal range 3.5-5.3 mEq/L). The progress notes further revealed the NP ordered intravenous fluids (IVFs) to be administered to resident #8. Further review of the medical record revealed resident #8 was transferred to the Emergency Room on September 17, 2010, after the facility staff was unable to maintain an (IV) access for the IV fluids. According to the Emergency Room report, resident #8 was being treated for Dehydration and Urinary Tract Infection (UTI). A review of the laboratory results obtained on September 17, 2010, revealed the BUN was 60 mg/dL (normal range 1-24 mg/dL) and the	F 157	audit residents' clinical records to ensure Hydration Policy and Protocol is being followed, residents' fluid needs are met and if not, the physician has been notified. 5) February 24, 2011	

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F 157	Continued From page 3 creatinine was 1.5 mg/dL (normal range 0.6-1.5 mg/dL). A review of the dietary intake records for November 1-18, 2010, revealed resident #8's average meal intake for breakfast was 37 percent, for lunch was 37 percent, and for dinner was 43 percent. On November 24, 2010, resident #8 was admitted to the hospital with a diagnosis of Urosepsis, Acute Atrial Fibrillation, and CHF. According to the hospital history and physical, the resident's BUN was 29 mg/dL and creatinine was 1.32 mg/dL. Resident #8 was readmitted to the facility on December 2, 2010. A review of the dietary intake records for December 3-21, 2010, revealed the resident's average meal intake for breakfast was 28 percent, for lunch was 17 percent, and for dinner was 25 percent. However, the facility failed to effectively monitor/evaluate the meal intake records. In addition, the facility failed to notify the resident's attending physician when the resident's meal intake decreased. A review of the nurse's notes dated December 21, 2010, revealed resident #8 was observed by staff to be less alert, repeating verbalizations, and leaning to one side. The resident's physician was contacted and orders were received to administer IV fluids and to obtain a chest x-ray and lab tests. A review of the lab test results obtained on December 22, 2010, revealed the resident's BUN was 73 mg/dL and the creatinine level was 2.9 mg/dL. Resident #8 was transferred to the hospital on December 22, 2010, for further evaluation and treatment and was admitted to the hospital with a diagnosis of Acute Volume Depletion, and Hypernatremia.	F 157		

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F 157	Continued From page 4 An interview conducted with the Certified Medication Aide (CMA) on February 23, 2011, at 10:40 a.m., revealed the CMA was responsible for transcribing the meal consumption information onto the dietary intake records and to monitor the resident's meal intake. The CMA further stated the resident's fluid consumption was not documented in the medical record unless the resident was on an Intake/Output (I&O). The CMA stated she was responsible to report to the charge nurse when a resident consumed less than 50 percent of their meals daily. The CMA was unable to recall if resident #8's decrease in intake had been reported to the charge nurse on December 2-21, 2010. An interview conducted with Licensed Practical Nurse (LPN) #1 on February 22, 2011, at 5:20 p.m., revealed the LPN was not familiar with the guidelines to consider when evaluating the resident's meal consumption records. The LPN stated she could not recall if the LPN was aware that resident #8 was not consuming the recommended fluid requirements prior to December 21, 2010. LPN #1 stated she could not recall if resident #8's decrease in po intake was reported to the resident's physician. An interview conducted with LPN #2 on February 22, 2011, at 6:30 p.m., revealed the Certified Medication Aides (CMAs) were responsible to monitor the resident's meal intake records and to report to the charge nurse immediately when the resident was not eating/drinking. LPN #2 stated the nurse was responsible to inform the resident's physician. The LPN stated whenever a resident concern was identified the concern should be documented on the Resident Concern Log. LPN #2 also stated she could recall resident #8 not	F 157		

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F 157	Continued From page 5 eating/drinking prior to going to the hospital, but the LPN could not recall if this information had been reported to the resident's physician. An interview with the Unit Manager (UM) on February 23, 2011, at 11:15 a.m., revealed the nurse was responsible for notifying the physician when a change occurred in the resident's condition. The UM stated the facility did not maintain a copy of the Resident Concern Log. In addition, the UM stated she could not recall whether other staff had reported to the UM that resident #8 was not consuming adequate food/fluids. The UM stated she did inform the physician of the changes in condition exhibited by resident #8 on December 21, 2010; however, the UM could not recall reporting the resident's poor po intake prior to that date. An interview conducted with the Director of Nurses (DON) on February 23, 2011, at 5:10 p.m., revealed the nurses were responsible to notify the attending physician when a change occurred in the resident's condition and when a "pattern" of poor po intake had been observed. The DON stated the physician notification should be documented in the resident's medical record. An interview conducted with physician (MD) #1 on February 23, 2011, at 2:35 p.m., revealed the MD did not review the resident's meal intake record when conducting visits with the residents. The MD stated resident #8 had severe cardiac disease with severe CHF and required occasional diuretic therapy for diuresis. MD #1 stated the resident was "very brittle" and could easily go from being in fluid overload to dehydration. MD #1 further stated he would have expected to be notified when the resident had consumed less	F 157		

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F 157	Continued From page 6 than 50 percent of meals for "a couple of days." MD #1 stated he could not recall being informed of the poor intake for resident #8 from December 2-21, 2010. The MD further stated if the MD had been informed a progress/assessment note should have been made in the medical record. An interview was conducted with the Nurse Practitioner (NP) on February 23, 2011, at 2:55 p.m. The NP stated she was at the facility each day Monday through Friday. The NP stated she would have expected to be informed of a resident's poor intake after the resident had not met fluid requirements or had a decrease in po intake for the first week. The NP stated she could not recall being informed of resident #8's poor po intake prior to December 21, 2010. In addition, the NP stated if she had assessed resident #8 a progress note should be in the medical record. However, there was no evidence a progress note had been made after December 2, 2010. Resident #8 was observed on February 21, 2011, at 12:25 p.m., to be lying in bed with a water pitcher noted on the resident's overbed table. At 4:00 p.m., resident #8 was again observed in the bed with eyes closed. A partially eaten sandwich and a 120cc glass containing approximately 60 cc of juice were observed on the overbed table.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	**F 280** It is and was on the days of survey, the policy of Berea Health Care Center to have a comprehensive care plan developed within seven days after the completion of the comprehensive assessment; prepared by an interdisciplinary team and revised when necessary.	

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F 280	Continued From page 7 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to review and revise the care plan for one of eighteen sampled residents. Resident #8 was transferred to the Emergency Room in September 2010 with a diagnosis of Dehydration. A care plan was developed to address the dehydration concern; however, after the resident received intravenous fluids the facility discontinued the plan of care for hydration. The facility failed to consider/evaluate all the risk factors related to dehydration and failed to review/revise the resident's care plan to include interventions to prevent/minimize the reoccurrence of dehydration for resident #8. (Refer to F157 and F327.) The findings include: Resident #8 was admitted to the facility on May 19, 2008, with diagnoses including Parkinson's Disease, Hypertension, Congestive Heart Failure (CHF), Osteoporosis, Osteoarthritis, Angina, and	F 280	1) After reviewing Resident #8's clinical record, intake and output flow sheet and food consumption, a care plan for at risk for dehydration was initiated on February 23, 2011. 2) All residents' care plans have been reviewed to ensure that all necessary care areas have been addressed. This audit was conducted by the Director of Nursing and Quality Assurance Nurse. 3) All RNs and LPNs were inserviced on February 24, 2011 by the Director of Nursing on the importance of updating the plan of care to reflect the residents' current needs and risks. 4) As part of the Quality Assurance Program, the Director of Nursing will audit ten percent of the care plans to ensure they reflect the residents' needs and risks. 5) February 24, 2011	

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F 280	Continued From page 8 Hyperlipidemia. Resident #8 was observed on February 21, 2011, at 12:25 p.m., to be lying in bed with a water pitcher noted on the resident's overbed table. At 4:00 p.m., resident #8 was again observed in bed with eyes closed. A partially eaten sandwich and a 120cc glass containing approximately 60 cc of juice were observed on the overbed table. A review of the significant change Minimum Data Set (MDS) assessment completed on May 17, 2010, revealed the facility assessed resident #8 to have cognitive impairment, to require limited assistance with eating, to leave 25 percent of meals uneaten, and to receive diuretic medications routinely. A review of the Resident Assessment Protocols (RAP) summary related to nutrition revealed the resident required follow-up feeding from staff due to weakness in the resident's extremities and was consuming 50 to 75 percent of the meals offered. Review of the Hydration RAP summary revealed the resident had been assessed to be at risk for dehydration related to the use of a diuretic medication and a diagnosis of CHF. A review of the quarterly MDS assessment completed on November 10, 2010, revealed the facility assessed resident #8 to have cognitive impairment, to require setup help with eating, and no diuretics administered in the past seven days of the assessment. A review of the comprehensive care plan dated May 19, 2010, revealed the facility developed a plan of care to address a risk for dehydration related to diuretic use. Interventions included to administer medications as ordered, obtain lab tests as ordered, observe for signs/symptoms of Urinary Tract Infection (UTI), and skin checks	F 280		

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F 280	Continued From page 9 every other day. The care plan was noted to be reviewed on August 17, 2010, and no changes were noted. However, the care plan was marked through and noted to be discontinued because the resident no longer required diuretic use after the quarterly review on November 10, 2010. The facility failed to evaluate the resident's risk factors for dehydration and failed to implement interventions to prevent dehydration for resident #8. A review of the physician's progress notes dated September 15, 2010, revealed the Nurse Practitioner (NP) assessed resident #8 due to mental status changes, a decrease in po intake, and abnormal lab test results. The NP noted the resident's BUN was 90 mg/dL, the Creatinine was 2.3 mg/dL, and the potassium level was 6.9 mEq/L. The NP ordered IVFs to be administered to resident #8. Further review of the medical record revealed resident #8 was transferred to the Emergency Room on September 17, 2010, after the facility staff was unable to maintain an (IV) access for the IV fluids. According to the Emergency Room report, resident #8 was being treated for Dehydration and UTI. A review of the laboratory results obtained on September 17, 2010, revealed the BUN was 60 mg/dL (normal range 1-24 mg/dL) and the creatinine was 1.5 mg/dL (normal range 0.6-1.5 mg/dL). Further review of the comprehensive care plan revealed an additional care plan was developed on September 15, 2010, due to the recent diagnosis of dehydration. The interventions included to administer medications as ordered, to encourage fluids, to keep the physician informed	F 280		

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F 280	Continued From page 10 of the resident's condition, and to administer IVFs. However, the IVFs were discontinued on September 20, 2010, and the care plan was discontinued at that time. There was no evidence the facility had identified the continued risk factors for dehydration and no evidence the facility had reviewed/revised the resident's plan of care related to the continued risks for dehydration. As a result the facility failed to develop/implement individualized interventions in an effort to prevent the reoccurrence of dehydration for resident #8. A review of the dietary intake records for December 3-21, 2010, revealed the resident's average meal intake for breakfast was 28 percent, for lunch was 17 percent, and for dinner was 25 percent. However, there was no evidence the facility identified that resident #8 failed to consume the recommended fluid requirements. Further review of the nurse's notes dated December 21, 2010, revealed the staff nurse observed resident #8 to be less alert, was repeating verbalizations, and leaning to one side. The facility staff nurse contacted resident #8's physician and orders were received to administer IV fluids and to obtain a chest x-ray and lab tests. A review of the lab test results obtained on December 22, 2010, revealed the resident's BUN was 73 and the creatinine level was 2.9. An interview conducted on February 23, 2011, at 3:50 p.m., with the MDS Nurses (LPNs #3 and #4) revealed a hydration care plan was generally developed when a resident received diuretic therapy. The MDS nurses stated when the diuretic was discontinued the care plan would also be discontinued/resolved. The MDS nurses also stated hydration risks should be determined	F 280		

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F 280	Continued From page 11 by the resident's lab tests results, po intake, skin turgor, and changes in the resident's condition. The MDS nurses further stated the plan of care should have been reviewed/revised to include the resident's continued risks for dehydration and poor po intake. The DON stated in an interview conducted on February 23, 2011, at 5:10 p.m., that the resident's plan of care should have been revised to include the resident's risk for dehydration with interventions to minimize/prevent the dehydration from reoccurring.	F 280		
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 meet accepted professional standards of quality for two of eighteen sampled residents (residents #4 and #18). The facility staff failed to verify resident #4's gastrostomy tube placement prior to the administration of medication via the gastrostomy tube. In addition, resident #18 had a physician's order for Natural Fiber to be administered in eight ounces of water; however, the nurse failed to mix the fiber with the prescribed amount of water prior to administration. The findings include: 1. An observation of a medication pass	F 281	**F 281** It is and was on the days of survey, the policy of Berea Health Care Center that services provided or arranged by the facility meet professional standards of quality. 1) The nurse that failed to verify g-tube placement on Resident #4 was inserviced on February 22, 2011 on the procedure and will enforce verifying g-tube placement prior to administering medication via g-tube. The CMA that failed to administer the appropriate amount of water with the Natural Fiber to Resident #18 was inserviced on following the directions on the Medication Administration Record and pharmacy protocols when administering Natural Fiber and/or other medications. 2) All residents that have a g-tube have been assessed by the Director of	

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	185384		C 02/23/2011

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F 281	Continued From page 12 conducted on February 22, 2011, at 4:10 p.m., revealed Licensed Practical Nurse (LPN) #1 administered medication to resident #4 via the gastrostomy tube route. The observation revealed LPN #1 crushed each medication separately and then added water to each crushed medication. LPN #1 flushed the resident's gastrostomy tube with water, and then administered each medication. The LPN flushed the resident's gastrostomy tube with 30 milliliters of water between each medication administered; however, there was no evidence the LPN checked the gastrostomy tube for placement prior to administering the medications. In an interview conducted on February 22, 2011, at 4:30 p.m., with LPN #1 she stated she did not verify resident #4's gastrostomy tube placement prior to administration of the medications. The LPN further revealed gastrostomy tube placement should have been verified prior to administering medication via the resident's gastrostomy tube. The LPN added resident #4's gastrostomy tube had been verified for placement earlier that day at approximately 1:00 p.m. An interview conducted on February 23, 2011, at 5:10 p.m., with the Director of Nursing (DON) revealed a resident's gastrostomy tube should have been checked to verify proper placement prior to the administration of any medication. The DON further revealed proper gastrostomy tube placement should have been verified with auscultation. Review of the facility's policy's on Enteral Tube Medication Administration (no date) revealed the policy did not address verification of placement of the gastrostomy tube prior to medication	F 281	Nursing to ensure that g-tube placement is verified. All RNs, LPNs and CMAs were inserviced on February 24, 2011 on the importance of administering Natural Fiber and other medication per pharmacy directions noted on Medication Administration Records and in the pharmacy protocols. 3) The Unit Coordinator will do a monthly observation of RNs and LPNs as they administer medications per g-tube to ensure placement verification is done prior to administering medications. On a quarterly basis, the Pharmacist will observe the administration of medication via g-tube to ensure placement verification is done prior to administering medications. The Unit Coordinator will do a monthly observation of a medication pass to ensure CMAs are administering Natural Fiber and other medications per pharmacy directions and protocols. On a quarterly basis, the Pharmacist will observe the CMAs during a medication pass to ensure they are administering Natural Fiber and other medication as director and per protocols.	

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F 281	Continued From page 13 administration. 2. A review of the medical record revealed resident #18 had a physician's order for Natural Vegetable Fiber 10 cc to be administered with eight ounces of water once a day. During the medication observation pass conducted on February 22, 2011, at 8:50 a.m., the Certified Medication Aide (CMA) was observed to pour 10 cc of the powdered fiber into a plastic medication cup. The CMA also poured approximately four ounces of water into a five-ounce drinking cup. The CMA was then observed to pour approximately 15 cc of water into the plastic medication cup and stirred the medication. The CMA then administered the medication to resident #18 with a plastic spoon and the resident was encouraged to consume the rest of the four ounces of water. An interview conducted with the CMA on February 22, 2011, at 9:20 a.m., revealed the CMA did not realize the medication was ordered to be administered in eight ounces of water. The CMA also stated he/she did not recognize the drinking cup was only a five-ounce cup. A review of the facility's policy/procedure related to Medication Administration (no date) revealed medications were required to be administered according to the written orders of the resident's attending physician.	F 281	4) As part of the Quality Assurance Program, the Director of Nursing will observe RNs and LPNs monthly to ensure they are verifying g-tube placement prior to administering medications via g-tube. As part of the Quality Assurance Program, the Director of Nursing will also observe CMAs on a monthly basis during a medications pass to ensure Natural Fiber and other medications are being administered per directions and protocols. 5) February 24, 2011	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312	**F 312** It is and was on the days of survey, the policy of Berea Health Care Center that care is provided to those residents that are unable to carry out activities of daily living themselves receive the necessary services to	

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F 312	Continued From page 14 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services to maintain good grooming and personal hygiene for one of eighteen sampled residents. Resident #10 was observed to have long facial hair and long fingernails with a dark brown substance underneath the resident's fingernails for two consecutive days of the survey. The findings include: Resident #10 was admitted to the facility on December 31, 2010, with diagnoses that included Osteoarthritis, History of Breast CA, Esophageal Dysmotility, and Hiatal Hernia. Resident #10 was observed on February 21, 2011, at 12:20 p.m., at 2:25 p.m., at 4:00 p.m., and at 6:25 p.m., to be sitting up in a wheelchair in the resident's room. The resident was observed to have long fingernails with a dark brown substance underneath the resident's fingernails. In addition, several long hairs were observed on the resident's chin area. Resident #8 was again observed on February 22, 2011, at 9:25 a.m., at 11:05 a.m., and at 1:35 p.m. The resident continued to have long fingernails and facial hair on the resident's chin. An interview was conducted on February 22, 2011, at 9:25 a.m., with resident #10. The resident stated he/she preferred to have the resident's fingernails and facial hair trimmed.	F 312	maintain good nutrition, grooming, and personal and oral hygiene. 1) Resident #10's nails were trimmed and facial hair was removed on February 22, 2011 by the CNA that was assigned to care for Resident #10. The CNA and other CNAs that were present on this day were inserviced on facility policy and the CNA's job description on grooming and personal care of Resident #10. 2) As a part of the routine care given on February 22, 2011, all residents' nails were checked, cleaned and trimmed as needed. During morning care on February 22, 2011, all male residents were shaved and all female residents were checked for long facial hair and the hair was removed unless the resident objected. All CNAs were inserviced on the facility policy, the CNA job description and the importance of providing good grooming and personal care daily, on bath days and as needed to all residents to ensure those needs are met. 3) The Charge Nurses are to observe daily to ensure that Resident #10 and all other residents' nails are clean and trimmed and they are free of facial hair.	

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F 312	Continued From page 15 Resident #10 stated he/she did not like other people seeing the resident with long fingernails and facial hair. A review of the comprehensive MDS admission assessment completed on January 12, 2011, revealed resident #10 was assessed to have no problems with recall, visual loss, and to require extensive assistance of staff for personal hygiene needs. A review of the comprehensive care plan dated January 17, 2011, revealed the facility addressed a concern related to self-care deficit. Interventions included to encourage the resident to participate in self-care, to remove facial hair daily, and to trim nails on bath days. An interview conducted with CNA #1 on February 22, 2011, at 2:25 p.m., revealed the resident care needs are identified on the CNA care plan. CNA #1 stated nail care should be provided on shower days (two days a week) and the resident's facial hair should also be trimmed on the resident's shower days and as needed. CNA #1 stated he/she had provided care for resident #10 but had never provided nail care or trimmed facial hair. CNA #3 stated in an interview conducted on February 22, 2011, at 9:45 a.m., that he/she had also provided care for resident #10. However, CNA #3 stated he/she had not trimmed the resident's fingernails or facial hair. An interview conducted with the Unit Manager (UM) on February 23, 2011, at 6:10 p.m., revealed resident care needs were monitored through daily resident rounds. The UM stated he/she had to remind the CNAs to provide nail care to residents at times.	F 312	4) As part of the Quality Assurance Program, the Director of Nursing and Unit Coordinators will randomly select residents monthly to ensure nails are clean and trimmed and they are free of facial hair. 5) February 24, 2011	

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F 312	Continued From page 16 A review of the facility's policy/procedure related to personal hygiene needs (no date) revealed shaving and nail care were considered grooming measures to prevent infection and to promote resident comfort. The policy also noted these care needs affect love, belonging, and self-esteem needs. The policy further directed the appropriate time to perform shaving and nail care was during the resident's bath time.	F 312		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide one of eighteen sampled residents (resident #8) with sufficient fluid intake to maintain proper hydration and health. Resident #8 was identified on September 17, 2010, to have a diagnosis of Dehydration. The facility failed to identify/evaluate all the risk factors that placed resident #8 at continued risk for dehydration. In addition, facility staff was inconsistent with the knowledge of the facility's system for documentation and monitoring of the residents to ensure each resident received appropriate fluid intake to maintain hydration. (Refer to F157 and F280.) The findings include: A review of the facility's Hydration Policy and Protocol (no date) revealed the resident's fluid	F 327	**F 327** It is and was on the days of survey, the policy of Berea Health Care Center to provide all residents with sufficient fluid intake to maintain proper hydration and health. 1) RNs and LPNs on duty on February 23, 2011 were re-educated on the Facility Hydration policy. A complete Hydration Assessment was done on Resident #8, the physician was notified of findings and interventions were put into place. 2) All residents that were having their fluid intake monitored per physician order were reviewed to ensure fluid requirements were met. All other residents were assessed to ensure they had no signs or symptoms of dehydration. This assessment was conducted by the RN & LPN Unit Coordinators. 3) The Dietitian will assess quarterly and as needed to ensure fluid requirements for each resident are noted and fluids are being offered on meal trays.	

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F 327	Continued From page 17 requirements were calculated by the dietitian and an interdisciplinary hydration assessment should be completed within 14 days of admission to the facility. The policy directed that reassessment would be done based on resident outcome. The policy noted the estimated fluid needs would be offered via the meal trays, snacks, and water at the resident's bedside. The policy identified risk factors to be considered for dehydration as residents with Foley catheters, gastrostomy tubes, intravenous fluids, and residents who are on a fluid restriction. In addition, the policy stated when a resident does not accept the fluid recommendations, the resident would be evaluated for signs/symptoms of dehydration and if the resident is free of signs/symptoms no further action would be required. Resident #8 was admitted to the facility on May 19, 2008, with diagnoses including Parkinson's Disease, Hypertension, Congestive Heart Failure (CHF), Osteoporosis, Osteoarthritis, Angina, and Hyperlipidemia. A review of the significant change Minimum Data Set (MDS) assessment completed on May 17, 2010, revealed the facility assessed resident #8 to have cognitive impairment, to require limited assistance with eating, to leave 25 percent of meals uneaten, and to receive diuretic medications routinely. However, a review of the Resident Assessment Protocols (RAP) summary related to nutrition revealed the resident required follow-up feeding from staff due to weakness in the resident's extremities and was consuming 50 to 75 percent of the meals offered. A review of the Hydration RAP summary revealed the resident had been evaluated to be at risk for dehydration related to the use of a diuretic	F 327	The Charge Nurses and Unit Coordinators will monitor daily residents who have a physician order to record fluid intake and monitor food consumption percentages of other residents. If the fluid needs are not being met or oral intake has decreased, the physician will be notified. 4) As part of the Quality Assurance Program, the Director of Nursing will educate staff daily and as needed on the importance of encouraging and appropriately documenting fluid intake and meal consumption. On a monthly basis, the Director of Nursing will randomly review intake and output and meal consumption records to ensure fluid needs are being met. 5) February 24, 2011	

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F 327	Continued From page 18 medication and a diagnosis of CHF. A review of the Nutrition Care Progress notes conducted by the Registered Dietitian (RD) on May 21, 2010, revealed resident #8 had been assessed to require 1400-1700 cc of fluids daily to maintain the resident's hydration status. A review of the physician's progress notes dated September 15, 2010, revealed the NP assessed resident #8 due to mental status changes, a decrease in po intake, and abnormal lab test results. The progress notes stated the resident's BUN was 90 mg/dL (normal range 1-24 mg/dL), the Creatinine was 2.3 mg/dL (normal range 0.6-1.5 mg/dL), and the potassium level was 6.9 mEq/L (normal range 3.5-5.3 mEq/L). The progress notes further revealed the NP ordered IVFs to be administered to resident #8. Further review of the medical record revealed resident #8 was transferred to the Emergency Room on September 17, 2010, after the facility staff was unable to maintain an (IV) access for the IV fluids. According to the Emergency Room report, resident #8 was being treated for Dehydration and UTI. A review of the laboratory results obtained on September 17, 2010, revealed the BUN was 60 mg/dL and the creatinine was 1.5 mg/dL A review of the comprehensive care plan revealed the facility addressed a concern related to dehydration on September 15, 2010. Interventions included to administer medications as ordered, to encourage fluids, to keep the physician and family informed of the resident's condition, monitor lab tests, and IVFs as ordered by the physician. However, the IVFs were	F 327		

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	185384	A. BUILDING B. WING	C 02/23/2011

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F 327	Continued From page 19 discontinued on September 20, 2010, and there was no evidence the facility had identified the continued risk factors for dehydration and no individualized interventions were implemented, in an effort to prevent the reoccurrence of dehydration for resident #8. A review of the dietary intake records for November 1-18, 2010, revealed resident #8's average meal intake for breakfast was 37 percent, for lunch was 37 percent, and for dinner was 43 percent. On November 24, 2010, resident #8 was admitted to the hospital with a diagnosis of Urosepsis, Acute Atrial Fibrillation, and CHF. According to the history and physical, the resident's BUN was 29 mg/dL and creatinine was 1.32 mg/dL. The resident was readmitted to the facility on December 2, 2010. A review of the dietary intake records for December 3-21, 2010, revealed the resident's average meal intake for breakfast was 28 percent, for lunch was 17 percent, and for dinner was 25 percent. However, there was no evidence provided to indicate the facility had an effective system to recognize the resident had failed to consume the recommended fluid requirements for 13 days, and therefore the facility failed to provide interventions to prevent the reoccurrence of dehydration for resident #8. A review of the nurse's notes dated December 21, 2010, revealed resident #8 was observed by staff to be less alert, repeating verbalizations, and leaning to one side. The resident's physician was contacted and orders were received to administer IV fluids and to obtain a chest x-ray and lab tests. A review of the lab test results obtained on December 22, 2010, revealed the resident's BUN was 73 and the creatinine level was 2.9.	F 327		

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F 327	Continued From page 20 A review of the skin turgor checks conducted every other day from December 2-21, 2010, revealed resident #8's skin turgor was documented as "good." An interview conducted with the certified nurse aides (CNAs #1 and #2) on February 22, 2011, from 2:25 p.m. through 5:20 p.m., revealed the CNAs were responsible to document the resident's meal intake on the daily assignment sheet and submit this information to the Medication Aide (MA) to document in the resident's medical record. The CNAs stated the resident's assessed fluid requirements were provided on the meal trays and fluids were required to also be offered to the resident whenever staff went into the resident's rooms. The CNAs stated the fluids were included in the meal consumption totals. In addition, CNAs #1 and #2 stated they recalled that resident #8 was not eating/drinking well prior to going to the hospital in December 2010 and also recalled being told by the nurse to encourage resident #8 to drink fluids. An interview conducted with the Certified Medication Aide (CMA) on February 23, 2011, at 10:40 a.m., revealed the CMA was responsible for transcribing the meal consumption information onto the dietary intake records and to monitor the resident's meal intake. The CMA stated the information only included the amount of foods consumed, but did not include the fluid intake for the resident. The CMA further stated the resident's fluid consumption was not documented in the medical record unless the resident was on an Intake/Output (I&O). The CMA stated she was responsible to report to the charge nurse when a	F 327		

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F 327	Continued From page 21 resident consumed less than 50 percent of their meals daily. The CMA was unable to recall if resident #8's decrease in intake had been reported to the charge nurse on December 2-21, 2010. An interview conducted with LPN #1 on February 22, 2011, at 5:20 p.m., revealed the LPN was not familiar with the guidelines to consider when evaluating the resident's meal consumption records. The LPN stated she could not recall if the LPN was aware that resident #8 was not consuming the recommended fluid requirements prior to December 21, 2010. An interview with the Unit Manager (UM) on February 23, 2011, at 11:15 a.m., revealed residents are assessed to be at risk for dehydration if the resident receives a diuretic, has poor skin turgor, and through the MDS assessment process. The UM stated the nurses were responsible to check the resident's skin turgor every other day and any concerns are to be documented and reported to the physician for further interventions. An interview conducted with the Administrator on February 23, 2011, at 2:15 p.m., revealed a Hydration Assessment was not conducted for a resident unless the resident had been assessed to fail to consume the recommended fluid requirements and if the resident was on I&O. The Administrator also stated the documentation on the dietary intake record should reflect both food and fluid consumption. An interview conducted with MD #1 on February 23, 2011, at 2:35 p.m., revealed resident #8 had severe cardiac disease with severe CHF. MD #1	F 327		

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F 327	Continued From page 22 stated the resident was "very brittle" and could easily go from being in fluid overload to dehydration. MD #1 also stated resident #8 required diuretic therapy at intervals due to CHF. The MD further stated skin turgor tests were not reliable to evaluate for dehydration in elderly residents due to skin thinning and loss of elasticity. Resident #8 was observed on February 21, 2011, at 12:25 p.m., to be lying in bed with a water pitcher noted on the resident's overbed table. At 4:00 p.m., resident #8 was again observed in bed with eyes closed. A partially eaten sandwich and a 120cc glass containing approximately 60 cc of juice were observed on the overbed table.	F 327		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**F 425** It is and was on the days of survey, the policy of Berea Health Care Center to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) to meet the needs of each resident. 1) The Unit Coordinator immediately notified the pharmacy when she was made aware that Resident #18 did not have the Deep Sea Nasal Spray in her medication drawer on February 22, 2011. The contract pharmacy contacted the local pharmacy and had the Deep Sea Nasal Spray delivered immediately. The CMA that was present was inserviced on February 22, 2011 on the importance of notifying the	

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	185384	A. BUILDING B. WING	C 02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEREA HEALTH CARE CENTER	601 RICHMOND ROAD, P O BOX 40 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 425	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of eighteen sampled residents. Resident #18 had a physician's order to receive Deep Sea Nasal Spray daily; however, the medication was not available for administration on February 22, 2011. The findings include: A review of the medical record revealed resident #18 was admitted to the facility on September 27, 2003, with diagnoses that included Arthritis, Anemia, Depression, and Allergic Rhinitis. A review of the physician's orders revealed two sprays of Deep Sea Nasal Spray were to be administered in the resident's nostrils daily. However, during the medication observation pass conducted on February 22, 2011, at 8:50 a.m., the medication was not administered to resident #18. A review of the Medication Administration Record (MAR) for February 2011 revealed the medication had been circled on February 2, 4, 11, 16, 18, 21, and 22, 2011. A review of the back side of the MAR revealed notations dated February 4, 11, 16, and 18, 2011, which stated the medication was not administered to resident #18 due to the medication being unavailable from the pharmacy. An interview conducted with CMA #1 on February 22, 2011, at 9:20 a.m., revealed the medication had been reordered from the pharmacy but the CMA could not recall the date the pharmacy had	F 425	Charge Nurse immediately if there was an order for a medication and it was not available. 2) All residents' medication orders were checked on February 22, 2011 to ensure all medications were available to be dispensed as per orders. All CMAs, RNs and LPNs were inserviced on February 24, 2011 regarding the policy for re-ordering medications and their responsibility to ensure this is being done. 3) On a weekly basis, the Unit Coordinators will randomly select residents to ensure all medications are available as per physician order. On a monthly basis, while doing the Medication Pass Audit, the Pharmacist will ensure all medications are present for the residents whose med passes she observes. 4) As part of the Quality Assurance Program, the Director of Nursing will check physician orders monthly to ensure medications that are ordered by the physician are present and are being ordered in a timely manner. 5) February 24, 2011	

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	185384		C 02/23/2011

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F 425	Continued From page 24 been notified. The CMA stated the circled initials on the MAR indicated the medication had not been given and the resident had probably not had the medication for the month of February. CMA #1 stated medications were to be reordered from the pharmacy when the supply was noted to be low by pulling the labels and faxing them to the pharmacy for refills. The CMA stated if the medication had not been received from the pharmacy staff was required to report this information to the nurse so that the pharmacy could be notified. CMA #1 stated she could not recall if the nurse had been informed that the medication had not been available to be administered to resident #18. An interview with the UM on February 22, 2011, at 9:35 a.m., revealed staff was required to pull labels for reordering resident medications. The UM stated the CMA or licensed nurse was required to check the medications daily and fax the labels to the pharmacy for refills. The UM was unable to provide written documentation to reflect the most recent reorder date for the nasal spray. The UM stated when medications were delivered to the facility, the nurse was responsible to verify the medications that the pharmacy delivered; however, there was no system in place to check the delivered order against the labels that had been faxed to the pharmacy. The UM contacted the pharmacy to obtain information regarding the last fill date for the nasal spray. According to the pharmacy, the nasal spray had not been filled since June 24, 2010. A review of the facility's policy/procedure related to Medication Ordering and Receiving from the Pharmacy (no date) revealed medication refills are to be reordered three to four days in advance	F 425		

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F 425	Continued From page 25 by peeling the reorder label from the prescription label and faxing this information to the pharmacy. The policy/procedure stated the authorized staff person was required to document on the delivery receipt that the medications were delivered to the facility and to report any discrepancies to the pharmacy or charge nurse.	F 425		
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 (3) Maintains a record of incidents and corrective actions related to infections. (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.	F 441	**F 441** It is and was on the days of survey, the policy of Berea Health Care Center 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. 1) The LPN that was on duty on February 22, 2011 and provided wound care to Resident #4 and Resident #8 was inserviced on this date regarding asceptic technique for wound care and facility policy regarding prevention of wound infections. 2) All residents were assessed by the Director of Nursing to ensure asceptic technique is being performed with dressing changes and no negative outcomes are noted. 3) The Wound Certified Nurse will do monthly wound care rounds with RNs and LPNs to ensure asceptic technique is being provided during wound care.	

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F 441	Continued From page 26 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, sanitary environment to help prevent the development and transmission of disease and infection for two of eighteen sampled residents. During wound care observation, the facility staff nurse failed to follow aseptic/clean techniques when performing wound care in an attempt to prevent the spread of infection for residents #8 and #4. In addition, resident #8 was identified to have Methicillin Resistant Staphylococcus (MRSA) infection of both the right lower leg and foot wounds. The findings include: 1. A review of the medical record revealed resident #8 had diagnoses that included Peripheral Vascular Disease (PVD) and stasis ulcers of the resident's bilateral lower extremities. A review of the February 2011 physician's orders revealed the following treatment orders: (1) clean the left posterior popliteal skin ulcer with wound cleanser, pat dry, apply an Aquacel dressing, and wrap with Kerlix daily, and as needed, (2) Cleanse the wound on the right lower leg with wound cleanser, pat dry, and apply a Versiva	F 441	4) As part of the Quality Assurance Program, the Director of Nursing will monitor three dressing changes each month for the next six months to ensure asceptic technique is being provided during dressing changes. 5) February 25, 2011	

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F 441	Continued From page 27 dressing every three days, and as needed, and (3) cleanse the right lateral foot wound with wound cleanser, pat dry, apply an Aquacel dressing, and cover with a Versiva dressing daily, and as needed. Wound care observation conducted on February 22, 2011, at 10:15 a.m., revealed the LPN obtained non-sterile 4x4 gauze, Kerlix, DermaKlenz wound cleanser, and Aquacel dressing from the treatment cart and took the supplies to the resident's room. The LPN placed the supplies on the overbed table on top of a paper towel. The LPN was observed to wash her hands and apply gloves and proceed to remove a soiled dressing (dried blood) from resident #8's left lower leg, exposing a wound measuring approximately three inches in length with steri-strips intact. The LPN then proceeded to remove a soiled dressing (dried blood) from the resident's right lower posterior leg, exposing two wounds; one measuring approximately 2.5 cm and one measuring approximately 4 cm. The LPN then proceeded to remove a bloody dressing with yellow drainage from the resident's right lateral foot, exposing an open wound measuring approximately 0.5 cm on the outer foot area. The LPN then removed the gloves and cleaned the scissors with an antiseptic wipe. No handwashing was observed to be performed at this time. After donning clean gloves, the LPN sprayed the 4x4 gauze with the wound cleanser and cleaned the wound on the resident's left lower leg (LLL). The LPN was observed to open a dressing and place the dressing over the LLL wound and cover the area with Kerlix wrap. Still using the same gloves, the LPN was observed to open the	F 441		

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F 441	Continued From page 28 Aquacel dressing package and, with the same gloved hands, laid the dressing on top of the outside of the package. The LPN was noted to cut several strips from the Aquacel dressing and laid them on top of the dressing package. The LPN then sprayed 4x4 gauze with the wound cleanser and proceeded to clean both wounds of the resident's right lower leg (RLL), using the same gauze for both wounds. The gauze was noted to be soiled with bloody drainage after the wounds were cleaned. The LPN was then noted to again spray 4x4 gauze with the wound cleanser and proceed to clean the resident's right lateral foot wound. While still wearing the same gloves, the LPN proceeded to pick up the Aquacel dressings from the table, placed a small strip of the dressing on the right lateral foot wound, and then placed a larger section of the dressing on top of the resident's exposed mattress. The LPN picked up the dressing from the mattress and placed the dressing over both wounds on the resident's RLL and wrapped the area with Kerlix gauze. The dressing from the resident's right lateral foot was then observed to fall onto the exposed mattress. The LPN stated she had forgotten to remove the Versiva dressing from the treatment cart and was observed to remove the soiled gloves and clean her hands with an antiseptic gel cleanser. After obtaining the Versiva dressing, the LPN again cleaned her hands with the hand gel and donned clean gloves. The LPN proceeded to open the Versiva dressing, pick up the dressing from the exposed mattress, and reapply the dressing to the resident's right lateral foot wound. The LPN then placed the Versiva dressing over the wound and wrapped the area with Kerlix	F 441		

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F 441	Continued From page 29 gauze. A review of the culture & sensitivity (C&S) tests conducted on February 18, 2011, of the resident's RLL wound and right lateral foot wound, revealed a heavy growth of Methicillin Resistant Staphylococcus (MRSA) was present in the wounds. A physician's order was obtained on February 21, 2011, for Bactrim DS to be administered twice a day for seven days. A review of the facility's policy/procedure related to Prevention of Wound Infections (dated 2007) revealed clean technique was required to be used when providing wound care to pressure or stasis ulcers. The facility's Handwashing policy/procedure (dated 2007) revealed handwashing was to be utilized to decrease the risk of transmission of infection and considered the most important single procedure for preventing infections. The policy/procedure further noted if a resident has been identified to have a spore-forming organism, handwashing should be performed by using soap and water. An interview conducted with LPN #1 on February 22, 2011, at 11:15 a.m., revealed the LPN had been trained to follow aseptic techniques when providing wound care. LPN #1 stated she should have washed her hands and changed gloves after removing the soiled dressings from resident #8's lower extremities. The LPN also stated she should have changed gloves between the different wound sites. In addition, LPN #1 stated she should have obtained clean dressings after the dressing had been placed on the mattress and fell off the foot wound. An interview conducted with the DON on	F 441		

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F 441	Continued From page 30 February 23, 2011, at 5:10 p.m., revealed she and the UM were responsible for the facility's Infection Control program. The DON stated aseptic technique should be maintained when wound care was provided for the residents. The DON stated this included changing gloves and performing handwashing between each wound site, after cleaning each wound, and before applying the dressings to the wounds. The DON stated staff performance of wound care was monitored through random observations of staff. The DON also stated Infection rates were tracked/trended monthly and no increase in incidence of MRSA had been identified. 2. Resident #4 was admitted to the facility on June 4, 2010, with diagnoses that included Diabetes Mellitus, Coronary Artery Disease, Cardiomyopathy, and Chronic Obstructive Pulmonary Disease. A review of the physician's orders dated February 22, 2011, revealed resident #4 was identified to have an open wound on each side of the resident's nasal bridge area. Orders were obtained to cleanse the wounds with wound cleanser, apply an Aquacel dressing over each site, and cover the area with a DuoDerm dressing daily. Observations of wound care provided by LPN #1 on February 22, 2011, at 10:45 a.m., revealed the nurse washed her hands and donned gloves, removed the soiled (no drainage) dressing from the left nasal bridge wound, and then proceeded to remove the soiled dressing with a small amount of dark yellow drainage from the right nasal bridge wound. The soiled dressings were placed into the trash bag/can next to the resident's bed. The LPN was observed to spray 4x4 gauze with the wound cleanser and to first	F 441		

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F 441	Continued From page 31 clean the left nasal bridge wound and then to clean the right nasal bridge wound, using the same gauze and the same gloves. The LPN was then noted to remove the soiled gloves and to put on clean gloves without performing handwashing procedures. The LPN then applied the Aquacel dressing to the left wound and covered the area with DuoDerm. LPN #1 was then observed to apply the Aquacel dressing to the right wound and cover this area with DuoDerm. The LPN was not observed to change gloves or perform handwashing between the two sites. The LPN proceeded to remove the trash bag from the can and placed the trash bag containing the soiled dressings onto the floor. LPN #1 was then observed to remove the soiled gloves, perform handwashing at the sink, and to put on clean gloves. The LPN removed the heel protector from resident #4's left foot and applied Betadine prep to the resident's left heel with the gloved hand. The heel protector was reapplied and the soiled gloves were removed and placed in the trash bag on the floor. Interview conducted with LPN #1 on February 22, 2011, at 11:15 a.m., revealed the LPN had been trained to follow aseptic techniques when providing wound care. LPN #1 stated she should have washed her hands and changed gloves after removing the soiled dressings from resident #4's wounds. The LPN also stated she should have changed gloves between the different wound sites. In addition, LPN #1 stated she should not have placed the trash bag on the resident's floor. No C&S reports had been ordered by the physician to be obtained for resident #4.	F 441		

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	185384	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/22/2011

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on February 22, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	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.