

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	RECEIVED JAN-13 2011		(X3) DATE SURVEY COMPLETED 12/16/2010
NAME OF PROVIDER OR SUPPLIER THE TERRACE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1043 BROOKLYN BOULEVARD BEREA, KY 40403 Division of Health Care Enforcement Branch			
(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	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 rights 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 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 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, it was determined the facility failed to review and revise the comprehensive care plan for one (1) of twenty-one (21) sampled residents. Resident #13 sustained a fall on December 6, 2010, and the care plan was not revised with interventions to prevent additional falls for the	F280	483.20 (d) (3), 483.10 (k) (2) RIGHT TO PARTICIPATE PLANNING CARE -- REVISE CP It is the policy of The Terrace Nursing and Rehabilitation Facility to assure the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Paula Inga Stunk RW TITLE *Administrator* (X5) DATE *1.12.11*

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.

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010	
NAME OF PROVIDER OR SUPPLIER THE TERRACE NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1043 BROOKLYN BOULEVARD BEREA, KY 40403		
(X4) IQ 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 280	<p>Continued From page 1 resident.</p> <p>The findings include:</p> <p>Review of the medical record for resident #13 revealed the resident had been admitted to the facility on December 29, 2006, with diagnoses which included Alzheimer's, Malignant Neoplasm of the Sigmoid Colon, Osteoarthritis, Muscle Weakness, Peripheral Vascular Disease, and Congestive Heart Failure.</p> <p>A review of the Incident/Accident Follow-up Assessment Form for resident #13 revealed the resident had sustained a fall on December 6, 2010. The causative factor was determined to be that the resident didn't realize he/she was too close to the edge of the bed and had fallen off the bed.</p> <p>A review of the Minimum Data Set (MDS) assessment dated October 12, 2010, revealed the resident had been assessed as being at risk for falls, and a care plan had been implemented to address the resident being at risk for falls. However, the comprehensive care plan had not been updated with new interventions to prevent additional falls for this resident after the fall on December 6, 2010.</p> <p>Observation of resident #13 on December 15, 2010, at 3:50 p.m., revealed the resident to be lying on a bed of medium to lower height. The bed was in the lowest position.</p> <p>An interview conducted with the Unit Coordinator (UC) for the South Wing of the facility on December 15, 2010, at 5:30 p.m., revealed the care plan for resident #13 should have been</p>	F 280	<p>planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed 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 residents, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Resident #13 does have a comprehensive plan of care that was developed by an interdisciplinary team. The plan of care has been reviewed and revised after each assessment. The resident was assessed to be at risk for falls and it was so indicated on the plan of care. The next MDS assessment was not due/scheduled until December 16, 2010. Resident #13 did sustain a fall on December 6, 2010. Within 24 hours our interdisciplinary team met about the fall and implemented new interventions to prevent additional falls. A bed that sit lower to the floor was given to the resident so that her feet would easily rest flat on the floor when she sat on the side of her bed. The nursing staff was in-serviced about the intervention. This approach was documented in the resident's medical record and placed on the Nurse Aide Care Plan on December 7, 2010. The intervention was in affect on the days of the survey and has been effective with the resident sustaining no additional falls.</p> <p>1. Resident #13 comprehensive plan of</p>	

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

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 12/16/2010
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 280	Continued From page 2 updated with new interventions after the fall the resident sustained on December 6, 2010. The UC stated the new interventions for residents who have sustained a fall were discussed in the weekly Medicare Quality Improvement Meeting. The UC further reported it was the responsibility of the MDS Coordinator or her/his designee to update the resident's care plan with the interventions discussed at the meeting. An interview conducted with the MDS Licensed Practical Nurse (LPN) on December 15, 2010, at 5:45 p.m., revealed the MDS Coordinator was currently on sick leave. The MDS LPN further stated he/she had attended the Medicare Quality Improvement Meeting on December 7, 2010, in which the fall resident #13 received on December 6, 2010, was discussed. The MDS LPN stated he/she was responsible for updating the care plan but had failed to update the care plan. The MDS LPN reported the care plan should have been updated the same day the meeting was held.	F 280	care was updated on December 15, 2010 to reflect the adjustable height – lower bed intervention. 2. On December 31, 2010 an audit done by facility RN/LPN Unit Coordinators was completed on all residents' comprehensive plan of cares that had been assessed for being at risk for falls. All comprehensive plan of cares had been updated with interventions. No discrepancies were identified. 3. On December 23, 2010 our Director of Nursing conducted an in-service with our RN/LPN MDS Nurses and our RN/LPN Nurse Unit Coordinators about timely updating comprehensive plan of cares with interventions. Each resident's comprehensive plan of care will be brought to the interdisciplinary meeting and interventions updated/added during the meeting. 4. A monthly audit will be conducted for the next three months (by our RN/LPN Nurse Unit Coordinators) and then an audit will be done on a quarterly basis to assure all fall interventions - for all residents that are assessed to be at risk for falling - were updated/added to the residents' plan of care timely. 5. Corrective actions were completed on January 3, 2011.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334	483.25 (n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS It is the policy of The Terrace Nursing and Rehabilitation Facility that (i) Before offering the influenza immunization, each	1/3/11

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

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 12/16/2010
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 334	Continued From page 3 immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment	F 334	resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or legal representative was provided education regarding the risks and benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. Resident #3 was offered her annual influenza immunization on September 23, 2010 as indicated on her physician orders and again on October 4, 2010 as documented on the facility annual flu vaccine summary record. Resident #3 refused the immunization both times. 1. On December 31, 2010 Resident # 3 was again offered her annual influenza immunization by our Director of Nursing. Resident #3 was given education verbally and in writing regarding the benefits and potential side effects of the influenza immunization. As she has for the past five years, the resident again refused the	

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

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 12/16/2010
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 334	<p>Continued From page 4</p> <p>and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the pneumococcal and flu vaccines were provided for one (1) of twenty-one (21) sampled residents (resident #3). The facility further failed to provide evidence the resident/responsible party had been informed of the health risks related to the immunizations.</p> <p>The findings include:</p> <p>A review of the medical record revealed resident #3 was readmitted to the facility on September 23, 2010. A review of the readmission physician's orders revealed the physician had prescribed an annual flu vaccine and a pneumococcal vaccine, if indicated.</p> <p>A review of the immunization record for resident #3 revealed the flu/pneumococcal vaccines were offered to the resident on October 11, 2009. The immunization record noted the resident refused the vaccines. However, there was no evidence the facility had offered the resident or responsible party (R/P) information regarding the risks/benefits of the flu/pneumococcal vaccines.</p>	F 334	<p>immunization. The resident's medical record was updated to include documentation that she did receive this offer and education and that she refused.</p> <p>2. On December 30, 2010 a medical record chart audit was completed by our Medical Records Clerk on all resident's medical records to assure that each resident had been given education regarding the benefits and potential side effects of the influenza immunization and that the acceptance or refusal of the immunization was documented. No further discrepancies were found.</p> <p>3. On January 7, 2011 the Director of Nursing conducted an in-service with facility licensed nurses (RNs/LPNs) on the need to provide education before offering the influenza immunization that included benefits and potential side effects of the immunization and place this information in the resident's medical record. Also, for the nurses to document acceptance and refusals of the immunization in the medical record.</p> <p>4. During influenza immunization months (October through March) an annual audit will be completed by our Director of CQI RN on all residents to assure all residents were given education of benefits and side effects of the influenza immunization before being offered their annual influenza immunization and that the nurses documented acceptance or refusal of the immunization in the medical record.</p> <p>5. Corrective actions were completed on January 10, 2011.</p>	1/10/11	

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
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 334	Continued From page 5 A review of the facility's Immunization policy/procedure (dated 2007) revealed the vaccines would be offered/administered to all current and newly admitted residents. The policy/procedure noted informed consent regarding risks/benefits of vaccination was required to be provided to the resident or R/P prior to the vaccination. An interview conducted with LPN #4 on December 15, 2010, at 3:10 p.m., revealed the LPN was responsible for completing the admission process for resident #3 when the resident was readmitted to the facility on September 23, 2010. LPN #4 stated the admitting nurse was responsible to provide/discuss the risks/benefits related to the flu and pneumococcal vaccines to the resident or the resident's R/P when a resident was readmitted to the facility. The LPN stated he/she did not provide the information related to the risks/benefits of the vaccines to resident #3 or the resident's R/P.	F 334		
F 441 SS=E	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 that we 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. On December 14 th a nurse administered subcutaneous injections to resident #20 and resident #21 without donning gloves. The 2010 position/guidance from the World Health Organization (WHO) and the Center	

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

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 12/16/2010
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 441	<p>Continued From page 6</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 record review, it was determined the facility failed to establish and maintain an effective infection control program to prevent the development and transmission of disease and infection for three (3) of twenty-one (21) sampled residents (residents #7, #20, and #21). Observation of medication administration on December 14, 2010, revealed staff administered subcutaneous injections to resident #20 and resident #21 without donning gloves. Observation of wound care for resident #7 on December 15, 2010, revealed staff failed to</p>	F 441	<p>for Disease Control (CDC) that wearing gloves are not required for subcutaneous injections was shared with our surveyor team.</p> <ol style="list-style-type: none"> Residents #7, #20 and #21 were all assessed by a facility RN/LPN nurse and monitored for any signs and/or symptoms of infection. To date, residents #7, #20 and #21 have not exhibited any signs or symptoms of infection. All residents receiving a subcutaneous injection or a wound treatment were identified by our Director of CQI. She observed facility RN/LPN nursing staff during treatments to these residents. No further infection control issues were identified. Observations for injections was completed on January 7, 2011. Observations for wound treatments was completed on December 29, 2010. On January 7, 2011 our Director of Nursing and our Director of CQI RN conducted an in-service on the facility Infection Control Program/Policies with our facility RN/LPN nurses. Nurses were instructed to wear gloves during injections and to change gloves when going from a soiled wound area to a clean area when doing a wound dressing change. For the next three months a monthly audit will be conducted by our Director of CQI RN to assure facility nurses are following the facility Infection Control Program/Policy related to wearing gloves with subcutaneous injections and changing gloves when going from a soiled area to a clean area during wound dressing changes. If after three months 	

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

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 12/16/2010
--	--	--	--

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 441	<p>Continued From page 7</p> <p>change gloves when going from a soiled area to a clean area.</p> <p>The findings include:</p> <p>1. During medication administration conducted on December 14, 2010, at 4:00 p.m., observation revealed Licensed Practice Nurse (LPN) #2 administered Novolin R Insulin subcutaneously to resident #20 without donning gloves. Additional observation conducted on December 14, 2010, at 4:30 p.m., revealed LPN #2 administered Novolog Insulin subcutaneously to resident #21 without donning gloves.</p> <p>In an interview conducted on December 14, 2010, at 4:35 p.m., LPN #2 revealed he/she did not wear gloves to administer subcutaneous injections of insulin and did not feel it was necessary to wear gloves. The LPN further stated he/she had not been trained by the facility to don gloves prior to the administration of subcutaneous injections.</p> <p>An interview conducted on December 15, 2010, at 12:20 p.m., with LPN #1 revealed he/she wore gloves to administer subcutaneous injections due to the risk of contact with blood and further stated the injection site could bleed during/after a subcutaneous injection.</p> <p>In an interview conducted on December 15, 2010, at 1:20 p.m., with the Director of Staff Development/Continuous Quality Improvement (DSD/CQI), the DSD/CQI stated staff would be at risk of exposure to blood/body fluids when administering an injection without the use of gloves. The DSD/CQI further revealed nurses were trained to don gloves prior to performing a</p>	F 441	<p>no issues are detected, the audit will be done quarterly. The audit will be a random sample of 10% of the residents with subcutaneous injections and wound dressings.</p> <p>5. Corrective actions were completed on January 10, 2011.</p>	1/10/11
-------	--	-------	---	---------

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

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 12/16/2010
--	--	--	--

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 441	<p>Continued From page 8</p> <p>venipuncture or intravenous catheters; however, the nurses were not trained to don gloves to administer a subcutaneous injection.</p> <p>In an interview conducted on December 15, 2010, at 9:55 a.m., with the Director of Nursing (DON), the DON stated the facility's policy did not require that gloves be worn to administer subcutaneous injections.</p> <p>Review of the facility's policy on Subcutaneous Medication Administration (not dated) stated that staff was required to don gloves to administer a subcutaneous injection. However, review of the facility's policy on Standard Precautions (2007) revealed gloves should be worn whenever exposure to blood or non-intact skin was planned or anticipated. The policy further stated all residents' blood, body fluids, excretions, and secretions other than sweat would be considered potentially infectious and gloves should be worn when providing care.</p> <p>2. A review of the medical record for resident #7 revealed the resident was admitted to the facility on September 17, 2002, with diagnoses to include Chronic Obstructive Pulmonary Disease, Chronic Wounds, and Quadriplegia. A review of the physician's orders revealed resident #7 had an order dated November 18, 2010, to cleanse the wound to the left and right buttocks, apply an Aquacel dressing, and cover with an ABD pad twice daily.</p> <p>Observation of skin assessment and wound care with Licensed Practical Nurse (LPN) #1 on December 15, 2010, at 1:30 p.m., revealed the LPN assessed resident #7 to have a Stage 4 decubiti to the left buttock, and a Stage 3 and a</p>	F 441		
-------	---	-------	--	--

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

PRINTED: 01/04/2011
FORM APPROVED
OMB NO. 0938-0391

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 12/16/2010
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 441	Continued From page 9 Stage 4 decubitus to the right buttock. Observation revealed LPN #1 used clean gloves to cleanse stool from the left buttock of resident #7 with a Prevail Adult Washcloth, and the LPN then placed a clean dressing on the wound, without washing/sanitizing hands or changing gloves (going from a soiled area to a clean area). A review of the facility's policy for Hand Hygiene revealed handwashing should be conducted when hands were visibly dirty or contaminated with proteinaceous material, were visibly soiled with blood or other body fluids, and in case of a resident with a spore-forming organism. The policy further revealed hand hygiene should be performed with either a non-microbial soap and water or antimicrobial soap and water. The policy further stated if hands were not visibly soiled, the staff was to use an alcohol-based hand rub for routinely decontaminating hands in all clinical situations other than those listed in handwashing.	F 441		

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

PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

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 12/15/2010
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	
K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on December 15, 2010, 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.</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.