

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

2nd SOD

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

MAY 31 2013

(X3) DATE SURVEY COMPLETED
04/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	
--	---	--	--

NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD 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 F 253 SS=D	<p>INITIAL COMMENTS</p> <p>A standard survey was conducted on 04/16-18/13. Deficient practice was identified with the highest scope and severity at 'D' level.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable interior. Observations during the environmental tour on 04/18/13 revealed the first and second floor shower rooms had grab bars with a brown discoloration. The second floor shower stalls had gray tile grout that was discolored black in the corners along the baseboards.</p> <p>The findings include: A review of the facility's Bathrooms policy (undated) revealed the bathrooms were to be maintained in a clean and sanitary manner. The bathrooms, including showers, whirlpools, bathtubs, commodes, etc., were to be cleaned daily.</p> <p>1. Observation of the first and second floor shower rooms on 04/18/13 at 11:00 AM revealed</p>	F 000 F 253	<p>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.</p> <p>F 253 It is and was on the days of survey, the policy of Berea Health Care Center to provide housekeeping and maintenance services necessary to</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm.	(X6) DATE 5-31-13
---	----------------------	-----------------------------

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: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD 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 253	<p>Continued From page 1</p> <p>the grab bars had a brown discoloration on them.</p> <p>Interview with the Housekeeping Supervisor on 04/18/13 at 2:00 PM revealed the bathrooms/shower rooms were cleaned daily, and the Supervisor stated rounds were made to ensure their cleanliness several times daily.</p> <p>Interview with the Assistant Administrator on 04/18/13 at 2:00 PM revealed he had observed the discoloration on the grab bars and, after close observation, determined the discoloration was rust. According to the Assistant Administrator, staff had cleaned the grab bars but the discoloration had not been removed.</p> <p>Interview with the Maintenance Director on 04/18/13 at 2:00 PM revealed the bars were observed to be rusty and maybe steel wool could clean the areas on the grab bars.</p> <p>2. Observation of the second floor shower stalls on 04/18/13 at 11:00 AM revealed the grout between the tiles was gray in color. However, the grout along the baseboards and corners of the shower stalls were observed to be black and discolored.</p> <p>Interview with the Housekeeping Supervisor on 04/18/13 at 2:00 PM revealed the black discoloration had been observed and Tilex was used on the area with no improvement. The Housekeeping Supervisor did not know what the black discoloration was.</p> <p>Interview with the Maintenance Director on 04/18/13 at 2:00 PM revealed the tiles and grout in the shower stalls had been replaced in the fall</p>	F 253	<p>maintain a sanitary, orderly, and comfortable interior.</p> <p>1. The grab bars in the shower rooms on first floor and second floor were all cleaned with steel wool by the Housekeeping Supervisor and maintenance staff on April 19, 2013.</p> <p>The grout in one of the shower stalls in Central Bath on second floor was thoroughly cleaned on April 19, 2013 then dried before applying a sealant to the grout. This shower stall was closed for 48 hours to allow it to properly dry per manufacture's recommendations. On April 25, 2013, the shower stall was reopened and the above procedure was followed for the second stall. The second stall was reopened on April 29, 2013.</p> <p>2. All staff will observe the specific areas in which they are working daily to ensure housekeeping and maintenance services are being provided in all areas of the facility to maintain a sanitary, orderly and comfortable interior. Per facility protocol, work order sheets are available in all departments and are to be filled out to notify the Housekeeping and Maintenance Supervisors of any repairs that need to be made. These sheets will be placed in the Housekeeping/Maintenance Supervisor mailbox for follow-up.</p> <p>3. The Housekeeping and Maintenance Supervisors will audit all areas of the</p>		

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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD 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 253	Continued From page 2 of 2012 due to discolored grout. According to the Maintenance Director after the tiles were replaced in the fall, a waterproofing product had been applied to the tiles in the shower stall on two or three different occasions, but the black discoloration had returned.	F 253	facility weekly on an ongoing basis to ensure all areas of the building are cleaned and in good repair to ensure a sanitary, orderly and comfortable interior per facility policy.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure emergency equipment was available to ensure proper treatment and care was provided for residents. Observation of the facility's emergency "crash cart" on the first floor revealed a suction canister was not available for use with the suction machine. The findings include: Review of the CPR (Cardiopulmonary Resuscitation) policy (undated) revealed the	F 328	4. As part of the Quality Assurance Program, the Quality Assurance Nurse, Assistant Administrator and Administrator will monitor all areas of the facility monthly on an ongoing basis to ensure all areas are orderly, sanitary and comfortable. The Housekeeping and/or Maintenance Supervisor will be notified of any areas or items that need to be cleaned or repaired. All work order sheets will also be reviewed during Quality Assurance meetings that are held every two months. In addition, this will be noted in the Quality Assurance minutes along with resolution and follow-up recommendations. 5. May 30, 2013. F 328 It is and was on the days of survey, the policy of Berea Health Care Center to ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	

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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD 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 328	<p>Continued From page 3</p> <p>"crash" cart would be stocked with a suction machine, airway, Ambu bag, oxygen, and CPR board to aid in a successful resuscitation for those residents who elected to have CPR performed.</p> <p>A review of the "Crash Cart Check List" (undated) revealed the Crash Cart was to be checked on Sunday nights, and the date, time, and initials of the nurse checking the cart were to be documented on the checklist. According to the review of the check sheet, staff had checked the Crash Cart on at 10:00 PM on Sunday, 04/14/13, and all of the items on the check sheet were noted to be available on the cart. However, observation of the facility's emergency Crash Cart on the first floor on Thursday, 04/18/13 at 11:45 AM, (three days after staff had checked the cart) revealed the cart did not contain a suction canister for the suction machine.</p> <p>Interview with the facility's first floor Unit Manager on 04/18/13 at 11:45 AM revealed night shift nurses checked the Crash Carts. The Unit Manager said when an item was used and/or had been removed from the cart and was not available to staff, the item should be replaced to ensure proper care and treatment was provided for residents.</p> <p>Interview with the Director of Nursing (DON) on 04/18/13 at 12:00 PM revealed in addition to the night shift nurse, the Quality Assurance nurse was to monitor the Crash Carts one time a week to ensure staff had checked the cart properly and that all of the equipment/supplies were on the cart.</p>	F 328	<p>Respiratory care; Foot care; and Prosthesis.</p> <p>1. On April 18, 2013, immediately upon being informed that the suction canister was missing from the crash cart on first floor, the canister was replaced.</p> <p>2. On April 18, 2013, a sign-off sheet was put into place. At the beginning of each shift, the on-coming and off-going nurses will check the crash carts on both floors to ensure that all emergency equipment is on each cart per facility policy.</p> <p>On April 18, 2013, all nurses were notified of the new sign-off sheet through the communication log that is checked at the beginning of each shift.</p> <p>All nurses attending the nurses inservice on April 26, 2013 were again informed of the importance of checking the crash carts on their scheduled floor and signing off that the check was completed and supplies are available prior to starting their shift. The inservice was conducted by the Quality Assurance/Staff Development Nurse.</p> <p>3. The Quality Assurance Nurse will monitor each crash cart three times per week to ensure that all emergency equipment is on the crash carts as per facility policy.</p>		

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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD 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 328	Continued From page 4 Interview with the Quality Assurance nurse on 04/18/13 at 1:30 PM revealed she routinely monitored the Crash Cart each Monday morning to ensure night shift staff had checked the Crash Cart and to ensure all equipment was ready and available for emergencies.	F 328	4. As part of the Quality Assurance Program, the Director of Nursing will randomly monitor crash carts to ensure that emergency equipment is on each crash cart and that the sign-off sheet is up to date on an ongoing basis.		
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	5. April 26, 2013. 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. A bulk laundry truck with a capacity to hold 38 bushels was ordered on April 19, 2013 and received on May 7, 2013 to ensure that no soiled linen bags are placed on the floor in the soiled linen room. 2. To provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection, on an ongoing basis, the Unit Coordinators and Charge Nurses will monitor staff daily to ensure that the Infection Control Program is effective and being followed by all staff per facility policy. 3. To provide a safe, sanitary and comfortable environment and to help		

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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD 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 5 (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 review of facility policy, it was determined the facility failed to maintain an effective infection control program. Observation on 04/18/13 of the laundry area revealed two laundry bags, filled with dirty linens, lying directly on the floor of the laundry room. The findings include: Review of the facility's Laundry Services policy (01/09/03) revealed the policy did not address the storage of soiled laundry. Observation of the laundry room on 04/18/13 revealed an area to deposit soiled linens, a separate area utilized to wash the soiled laundry, and another area to store the clean laundry. Continued observation revealed two clear plastic laundry bags filled with dirty laundry lying directly on the laundry floor. Interview with the Housekeeping Supervisor on 04/18/13 at 1:40 PM revealed staff placed soiled linens/clothing into a clear plastic bag prior to leaving the resident rooms, placed the clear plastic bags in a laundry cart, and took the cart to the laundry area. At that time, the staff removed the clear plastic bags filled with soiled	F 441	prevent the development and transmission of disease and infection, the Quality Assurance/Staff Development Nurse will monitor all staff on an ongoing basis, inservice all new staff at time of hire and inservice current staff now and annually to ensure that the Infection Control Program is being followed. The Quality Assurance Nurse will notify the Infection Control Nurse of any potential problems or concerns that she notes for follow-up by the Infection Control Nurse. 4. As part of the Quality Assurance Program, the Infection Control Nurse will review all infections and any concerns noted by the Quality Assurance Nurse monthly on an ongoing basis to ensure a safe, sanitary and comfortable environment is provided and to prevent the development and transmission of diseases and infections. If a problem is noted with the Infection Control Program, the Quality Assurance Committee will make changes to the Infection Control Program and monitor the effectiveness of the changes. 5. May 30, 2013.	

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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

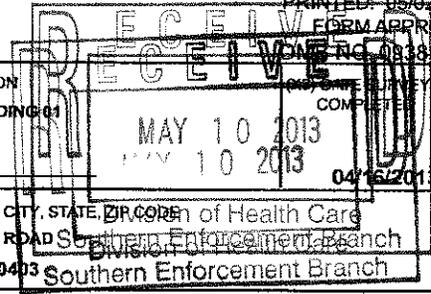
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD 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 6 linens/clothing and placed the bags directly on the floor for sorting the linens. The Housekeeping Supervisor acknowledged the plastic bags could sustain tears in the plastic and the soiled linens could come into direct contact with the floor. Although the Housekeeping Supervisor stated the laundry bags filled with soiled linens should not be placed on the floor, she stated, "There was nowhere else to put the dirty laundry bags." Interview with the Administrator on 04/18/13 at 3:10 PM confirmed the facility's policy did not address the storage of laundry bags filled with soiled linens. However, the Administrator stated the laundry bags filled with dirty linen should be placed in laundry carts in the laundry area designated for soiled linens.	F 441			

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

PRINTED: 05/02/2013

FORM APPROVED

NC 4848-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____
--	--	--

NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD BEREA, KY 40403 Division of Health Care Southern 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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1962</p> <p>Facility type: SNF/NF</p> <p>Type of structure: 2 story Type II protected with partial basement under kitchen</p> <p>Smoke Compartments: 6</p> <p>Fire Alarm: Complete addressable fire alarm system</p> <p>Sprinkler System: Complete automatic sprinkler system (wet)</p> <p>Generator: Natural gas</p> <p>A life safety code survey was initiated and concluded on 04/16/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p>	K 000	<p>K 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.</p>	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating</p>	K 062	<p>K 062 It is and was on the days of survey the policy of Berea Health Care Center to maintain automatic sprinkler</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wicki [Signature] TITLE: Adm. (X6) DATE: 5-10-13

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: 05/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD 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 062	<p>Continued From page 1</p> <p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler requirements were maintained. This deficient practice affected two of six smoke compartments, staff, and approximately twenty-five residents. The facility has the capacity for 84 beds with a census of 79 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 04/16/13 at 11:00 AM with the Director of Maintenance (DOM), inadequate sprinkler coverage was observed on the first floor shower room. The walls in the shower room would prevent the sprinkler pattern from reaching all areas in this room.</p> <p>An interview with the DOM on 04/16/13 at 11:00 AM revealed he was not aware of the improper sprinkler coverage. In addition, during the survey the second floor shower room was observed to have inadequate sprinkler coverage as well due to the walls preventing the sprinkler pattern from reaching all areas in this room.</p> <p>The findings were revealed to the Administrator during exit.</p> <p>Reference: NFPA 13 (1999 Edition).</p>	K 062	<p>systems that are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <ol style="list-style-type: none"> 1. On April 16, 2013, Sentry Fire Protection was notified of the need to install another sprinkler in each of the Central Baths to ensure adequate sprinkler coverage in shower stalls. Installation was scheduled for April, 24, 2013. 2. On April 24, 2013, Sentry Fire Protection installed an additional sprinkler in each Central Bath, located to ensure adequate sprinkler coverage to all shower stalls. <p>After the installation of the additional sprinklers, the deficient practice no longer exists.</p> <ol style="list-style-type: none"> 3. See above. 4. See above. 5. April 24, 2013. 	

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

PRINTED: 05/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185384	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD 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 062	Continued From page 2 5-5.5.1* Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard.	K 062			