

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



PRINTED: 11/25/2014
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 10/23/2014
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD BEREA, KY 40403 <i>Division of Health Care Southern Enforcement Branch</i>		
(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	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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164	F 164 It is and was on the days of survey the policy of Berea Health Care Center to ensure residents the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications,		

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

TITLE

(X6) DATE

Wicki Shantz

Adm

11-25-14

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 164	<p>Continued From page 1</p> <p>Based on observation, interview, and record review the facility failed to provide privacy during resident care for one (1) of fifteen (15) sampled residents (Resident #2). On 10/22/14, during a skin assessment and treatment observation for Resident #2, the window blinds were left open in full view of a residential dwelling.</p> <p>The findings include:</p> <p>A Rights of Residents policy, with no date, provided by the facility revealed all residents shall have personal privacy and confidentiality of their personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. Residents shall be assured of at least visual privacy in multi-bed rooms and in tub, shower, and toilet rooms. Each resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in medical treatment and in personal care.</p> <p>Interview on 10/23/14 at 10:15 AM with the Administrator revealed there was no specific policy for privacy but she did expect privacy to be provided during resident care.</p> <p>Record review revealed Resident #2 was admitted to the facility on 03/08/10 with diagnoses that included Atrial Fibrillation, Diabetes Mellitus II, Hypothyroidism, Depression/Anxiety, Cataracts, Chronic Low Back Pain, Hypertension, Mild Aortic Stenosis, Alzheimer's, Obesity, and Osteoarthritis. Review of a Quarterly Minimum Data Set dated 10/04/14 revealed the resident was assessed as totally dependent on staff for activities of daily living and to have severe</p>	F 164	<p>personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>1) Licensed Practical Nurse (LPN) #1 who was providing the skin treatment to Resident #2 was in-serviced on the importance of providing privacy (including closing blinds) when providing skin treatments to Resident #2 and all other residents.</p> <p>2) In-services were conducted on October 23, 2014 and November 6, 2014 for all Nursing Staff regarding privacy and confidentiality to ensure that privacy is provided (including closing blinds) when providing personal care and treatments to all residents.</p> <p>3) On a weekly basis, the Director of Nursing and Unit Coordinators will observe five Nursing Staff to ensure that privacy is provided (including closing blinds) when providing personal care and treatments to residents.</p> <p>At the scheduled monthly in-services, the Staff Development Nurse will continue to in-service the Nursing Staff regarding all residents' right to privacy. As part of the orientation process, all new hires will receive a copy of "Resident Rights". New hires will also be informed of the right to privacy (including closing blinds) when providing personal care and treatments to all residents.</p> <p>4) On a weekly basis, the Quality Assurance Nurse will observe five Nursing Staff as they provide personal</p>	

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F 164	Continued From page 2 cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3. Observation on 10/22/14 at 2:00 PM revealed Licensed Practical Nurse (LPN) #1 did not close the window blinds in Resident #2's room before providing treatment and before conducting a skin assessment. There was a clear view of a residential dwelling from the resident's window. Interview on 10/22/14 at 2:35 PM with LPN #1 revealed she should have shut the window blinds before providing care to Resident #2. Interview on 10/23/14 at 9:30 AM with the Unit Manager revealed another residential dwelling could be seen from Resident #2's window. Interview on 10/23/14 at 2:30 PM with the Director of Nursing (DON) revealed she expected staff to provide privacy to residents when providing care by shutting the door, closing the privacy curtain, and closing the blinds.	F 164	care or treatments to residents to ensure that privacy is provided (including closing blinds). The outcomes will be discussed as needed and at monthly Quality Assurance Meetings. 5) November 7, 2014.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to maintain a sanitary, orderly, and comfortable interior. Resident equipment (bath basins) was stored on the floor and resting inside one another in two resident bathrooms adjoining resident rooms 104	F 253	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 maintain a sanitary, orderly, and comfortable interior. 1) The resident equipment (wash basins) was removed from resident rooms 104, 105, 106 and 107 and discarded. Staff was in-serviced at that time regarding the proper storage (in the top of resident closets or in the bottom drawer of resident night stands) of wash basins. The Nursing Staff was also in-serviced on labeling resident equipment (wash basins) with the resident name.	

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F 253	<p>Continued From page 3 and 105. These two rooms adjoined rooms 106 (with 104) and 107 (with 105). These bathrooms were shared between two rooms.</p> <p>The findings include:</p> <p>Interview on 10/23/14 at 10:15 AM with the Administrator revealed there was no specific policy for the storage of residents' bath basins, but bath basins should be stored in the bottom drawer of the bedside table or in the closet labeled with the resident's name or bed #1 or bed #2 on the bath basin.</p> <p>Observations on 10/21/14 at 9:52 AM revealed two bath basins stored inside one another in the adjoining bathroom of resident rooms 105 and 107.</p> <p>Observations on 10/21/14 at 10:00 AM revealed three bath basins resting stored inside one another in an adjoining bathroom of resident rooms 104 and 106.</p> <p>Observation on 10/22/14 at 9:05 AM revealed two bath basins resting inside one another in the adjoining bathroom of resident rooms 105 and 107, and three bath basins resting inside one another in the adjoining bathroom of resident rooms 104 and 106.</p> <p>Observation on 10/22/14 at 1:40 PM revealed five bath basins stored inside one another in the adjoining bathroom of resident rooms 104 and 106, and two bath basins resting inside one another in the adjoining bathroom of resident rooms 105 and 107.</p> <p>Interview on 10/22/14 at 1:40 PM with SRNA #1</p>	F 253	<p>2) All resident bathrooms were checked to ensure that no resident equipment (wash basins) was stored on the floor in the bath rooms. During this check, any resident equipment (wash basins) that was found was discarded. New equipment (wash basins) was labeled with resident name and stored in the top of the resident closet and/or in the bottom drawer of the resident night stand.</p> <p>3) The Nursing and Housekeeping Staffs have been in-serviced on the proper storage technique of resident equipment (wash basins). At the time of this in-service, they were informed that if a labeled item (wash basin) is found in a resident bathroom, it is to be placed in the top of the resident closet or in the bottom drawer of the resident nightstand. These staff members were also informed to discard any resident equipment (wash basins) that are not labeled.</p> <p>All Housekeeping and Nursing Staff members were in-serviced on or before November 6, 2014.</p> <p>4) As part of the Quality Assurance program, on a monthly basis, the Quality Assurance Nurse will conduct random audits to ensure that resident equipment (wash basins) is labeled with resident name and stored properly.</p> <p>5) November 7, 2014.</p>		

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F 253	Continued From page 4 revealed bath basins should not be stored inside one another. The SRNA said the basins are supposed to be stored in the top of the closet with the resident's name on them and the basins should not be on the floor. Interview on 10/22/14 at 1:50 PM with SRNA #2 revealed bath basins are not supposed to be on the bathroom floor. The SRNA said bath basins should be stored in the closet or the bottom drawer of the bedside table labeled with the name and room number of the resident. The bath basins are to be stored in plastic bags. Interview on 10/22/14 at 1:40 PM with Registered Nurse (RN) revealed bath basins should have the resident's name and room number on them but was not sure where they should be stored in the resident's room. Interview on 10/22/14 at 1:43 PM with Licensed Practical Nurse (LPN) #1 revealed bath basins should not be stored on the bathroom floor and usually are stored in a clear bag on the back rail in the bathroom. Interview on 10/23/14 at 2:30 PM with the Director of Nursing (DON) revealed she expected staff to dry out the bath basins after use and store the bath basins in the top of the closet with the resident's name and room number on the basin.	F 253			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F 282 It is and was on the days of survey the policy of Berea Health Care Center that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.		

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F 282	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review of physician orders, medication administration record, and hospital discharge orders, it was determined the facility failed to follow the plan of care for medications for one (1) of fifteen (15) sampled residents (Resident #10). Resident #10 did not receive Pradaxa (oral anticoagulant/blood thinner) every twelve hours (q12h) per the plan of care and as ordered by the physician.</p> <p>The findings include:</p> <p>Record review of facility policy dated 08/01/13 entitled "Using the Care Plan," revealed the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Daily care and documentation must be consistent with the resident's care plan.</p> <p>Record review revealed Resident #10 was admitted to the facility on 08/29/14 with diagnoses that included Atrial Fibrillation, Hypertension, Cerebral Vascular Disease, Right Hemiparesis, and Expressive and Receptive Aphasia. A review of Resident #10's quarterly Minimum Data Set (MDS) dated 09/12/14 revealed the facility assessed the resident to have modified independence related to cognitive skills for daily decision-making and to require extensive assistance with activities of daily living.</p> <p>Record review of Resident #10's hospital discharge summary and physician's orders dated</p>	F 282	<p>1) Kentucky Medication Aide (KMA) #2 who was dispensing medications to Resident #10 was immediately in-serviced by the Director of Nursing (DON) stressing that when dispensing medications, physician orders and care plans must be followed and that it is not within the KMA's scope of practice to make any alterations to any medication administration record (MAR).</p> <p>The Physician's Nurse Practitioner was in the facility at this time and did write a clarification order that the Pradaxa for Resident #10 could be administered at 9:00 a.m. and 5:00 p.m. (B.I.D.) as it had been in the past. This change was noted on the care plan and MAR.</p> <p>2) The records of all residents who were receiving the medication Pradaxa were checked to ensure that the medication was being given at the times ordered by the Physician and that the care plans were being followed. All KMAs were in-serviced regarding their scope of practice on October 30, 2014 stressing that physician orders and care plans must be followed for each resident and KMAs are not permitted to alter any medication administration times.</p> <p>In the future, KMAs will notify a licensed nurse to seek clarification if they feel that a MAR has been altered. This will ensure that medications are being dispensed as ordered by the Physician and the care plan is being followed for all medications.</p> <p>3) On a monthly basis, the Medical Records Staff will review and compare</p>		

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F 282	<p>Continued From page 6</p> <p>06/10/14 revealed a physician's order for Resident #10 to receive Pradaxa 150 milligrams (mg) every 12 hours by mouth.</p> <p>Review of Resident #10's Medication Administration Record (MAR) for 06/11/14 through 10/21/14 revealed the facility administered Pradaxa U-D 150 mg at 9:00 AM and 5:00 PM, not every 12 hours as ordered by the resident's physician.</p> <p>Review of Resident #10's care plan with a resolution date of 12/21/14 revealed the facility identified the resident was at risk for spontaneous bleeding related to anticoagulant use, and developed interventions that included administering the resident's medication per Medical Doctor (MD) orders.</p> <p>Observation on 10/21/14 at 4:41 PM during medication pass revealed Kentucky Medication Aide (KMA) #2 obtained Pradaxa 150 mg from Resident #10's medication drawer to give to Resident #10.</p> <p>Interview on 10/23/14 at 3:00 PM with Licensed Practical Nurse (LPN) #1 revealed staff should follow all care plans completely.</p> <p>Interview on 10/23/14 at 2:30 PM with the Director of Nursing (DON) revealed she expected staff to look at the plan of care for the resident because it included the specific care for each resident. The DON said if there was a question about an order then there should be an order clarification. The DON stated if a medication order was written for a medication to be given every 12 hours and was not given every 12 hours, then she would consider this a medication error.</p>	F 282	<p>the physician orders to the MARs to ensure that medications are being dispensed at the times ordered by the Physician and that the care plan is being followed for each resident. The Medical Records Staff will inform the Licensed Unit Coordinator of any discrepancies. The Licensed Unit Coordinator will immediately clarify any discrepancies.</p> <p>4) On a monthly basis, as part of the Quality Assurance program, the Quality Assurance Nurse will audit ten residents' physician orders that have been recently initiated and MARs to ensure that everything is accurate and that care plans are being followed.</p> <p>5) October 30, 2014.</p>	

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F 282	Continued From page 7 The DON said she had no idea who would have changed Resident #10's medication order. According to the DON, the facility did not have a policy for medication times on specific halls or units. Interview on 10/22/14 at 4:50 PM with the Physician of Resident #10, and Medical Director of the facility, revealed staff should have acquired an order to change the administration time of the Pradaxa. The Physician stated it was better to take the medication (Pradaxa) every 12 hours.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, review of physician's orders, and review of medication administration records (MARs) it was determined the facility failed to follow physician's orders for one (1) of fifteen (15) sampled residents (Resident #10). Resident #10 had a physician's order to receive the medication Pradaxa (oral anticoagulant/blood thinner) every twelve hours (q12h); however, the facility administered the medication at 9:00 AM and 5:00 PM (eight and sixteen hours between doses)	F 309	F 309 It is and was on the days of survey the policy of Berea Health Care Center that each resident receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1) Kentucky Medication Aide (KMA) #2 was immediately in-serviced by the Director of Nursing (DON) when the discrepancy between Resident #10's Medication Administration Record (MAR) and the physician order was noted. The DON informed KMA #2 that medications must be administered at the times ordered by the Physician and times may only be altered if and when the Physician (or his practitioner) changes the order. The KMA was also informed that only a Licensed Nurse is permitted to make changes to a MAR after receiving an order from the Physician.	

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F 309	<p>Continued From page 8 instead of every 12 hours as ordered.</p> <p>The findings include:</p> <p>Record review of facility policy dated 08/01/13 and entitled "Physician Medication Orders," revealed medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Orders for medications must include: a. Name and strength of the drug; b. Quantity or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration if other than oral; and e. Reason or problem for which given.</p> <p>Review of a facility form entitled "Drug Pass Information," revealed the steps to take during the drug pass: When pulling medications, check resident's MAR, pull the appropriate drugs from the script boxes, and then double check them against the MAR. This will reduce the chance for a wrong medication to be given. (MAR should be double-checked). If there is a discrepancy between the two, find out the accurate drug prior to giving the medication.</p> <p>Record review revealed Resident #10 was admitted to the facility on 08/29/14 with diagnoses that included Atrial Fibrillation, Hypertension, Cerebral Vascular Disease, Right Hemiparesis, and Expressive and Receptive Aphasia. Review of a Quarterly Minimum Data Set dated 09/12/14 revealed Resident #10 was assessed to require extensive assistance with activities of daily living and the resident was assessed as modified independent related to cognitive skills for daily decision-making.</p>	F 309	<p>2) All KMAs were in-serviced on October 30, 2014 regarding Berea Health Care Center's policy to dispense medications at the times ordered by the Physician and that KMAs are prohibited from altering the times on the MAR.</p> <p>All MARs were reviewed to ensure that all residents were receiving their medications at the times ordered by the Physician or his practitioner.</p> <p>3) The Medical Record Staff will review all resident MARs on a monthly basis during change-over to ensure that all medication administration times correspond with the physician orders.</p> <p>Before putting the new monthly MARs into use, a Licensed Charge Nurse will also conduct a review to ensure that the times are accurate and medications are being dispensed at the times indicated on the physician orders.</p> <p>4) On a monthly basis, the Quality Assurance Nurse will observe two KMA medication passes to ensure that medications are being dispensed at the times ordered by the Physician. The Pharmacy Technician will observe a KMA medication pass to ensure that medications are being dispensed at the times ordered by the Physician.</p> <p>5) November 1, 2014.</p>		

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F 309	<p>Continued From page 9</p> <p>Review of Resident #10's care plan with a resolution date of 12/21/14 revealed an intervention of medication per MD orders for risk of spontaneous bleeding related to anticoagulant use.</p> <p>Record review of Resident #10's discharge summary from the hospital dated 06/10/14 revealed Pradaxa 150 milligrams (mg) was to be given every 12 hours by mouth. Review of handwritten physician's orders dated 06/10/14 revealed Resident #10 was to receive Pradaxa 150 mg by mouth every 12 hours. Record review of Physician Orders dated July 2014, August 2014, and October 2014 revealed Resident #10 was to receive Pradaxa 150 mg po q12h for 60 days unless otherwise noted.</p> <p>Review of Medication Pass Times revealed the timeframe for medication orders labeled every twelve hours (q12h) would be 9:00 AM and 9:00 PM for rooms that encompassed Resident #10's room.</p> <p>Record review of dates for June 2014 MARs handwritten upon return from the hospital, with a date of 06/10/14, revealed Resident #10 was to receive "Pradaxa 150 mg q12h po daily" with a timeframe of 8A and 8P written in and medication initialed as given on 06/10/14 at 8:00 PM.</p> <p>Review of Resident #10's Medication Administration Record (MAR) for 06/11/14 through 10/20/14 revealed the facility administered Pradaxa U-D 150 mg at 9:00 AM and 5:00 PM, not every 12 hours as ordered by the resident's physician.</p> <p>Interview on 10/21/14 at 4:45 PM with Kentucky</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>Medication Aide (KMA) #2 revealed Resident #10 received Pradaxa 150 mg at 5:00 PM, instead of the 12-hour interval as prescribed, on 20 occasions during October 2014. The KMA said she did not know who changed the time.</p> <p>Interview on 10/22/14 at 11:15 AM with KMA #1 revealed every 12 hours meant medication was due at 12-hour intervals, such as 6A/6P or 12P/12A. KMA #1 stated the charge nurse would have to call the physician to change the order from every 12 hours to twice a day (BID) or get a clarification order. The KMA said the medication administration times could not be changed without an order to change the dosage time.</p> <p>Interview on 10/23/14 at 3:00 PM with Licensed Practical Nurse (LPN) #1 revealed staff was to follow physician's orders when administering medications and if there was no physician's order then the medications were not given. LPN #1 stated she did not know who changed the order for Resident #10's Pradaxa.</p> <p>Interview on 10/21/14 at 4:44 PM with LPN #2 revealed there was no physician's order in Resident #10's chart signifying a change in the medication administration time for Resident #10's Pradaxa.</p> <p>Interview on 10/23/14 at 1:35 PM with the Pharmacy Consultant revealed she looked at residents' charts every month, and she also looked at resident medical records when they were readmitted to the facility. The Pharmacy Consultant stated she reviewed the resident discharge summaries upon readmission. According to the Pharmacy Consultant, she reviewed the admission orders or readmission</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>orders and compared those orders to the handwritten physician order sheet. The Pharmacy Consultant stated that Pradaxa could be administered twice a day at 9:00 AM and 5:00 PM or every 12 hours at 9:00 AM and 9:00 PM. The Pharmacy Consultant stated if the physician ordered the medication every 12 hours then it should be given as ordered. The Pharmacy Consultant stated there were no adverse effects to the resident due to the change in administration times.</p> <p>Interview on 10/22/14 at 10:15 AM with the Unit Manager revealed a physician's order was required before staff could change medication administration times. The Unit Manager stated she did not know who changed the order for the time of administration for Resident #10's Pradaxa.</p> <p>Interview on 10/23/14 at 2:30 PM with the Director of Nursing (DON) revealed if there was a question about an order then there should be an order clarification. The DON stated if an order was written for every 12 hours and not given every 12 hours then she would consider this a medication error. The DON said she had no idea who would have changed Resident #10's medication order. According to the DON, the facility did not have a policy for medication times on the halls or units.</p> <p>Interview on 10/22/14 at 4:50 PM with the Physician of Resident #10, and the Medical Director of the facility, revealed staff should have acquired an order to change the administration time of the Pradaxa. The Physician stated it was better to take the medication (Pradaxa) every 12 hours.</p>	F 309			

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F 367 SS=D	<p>483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide a therapeutic diet as prescribed by the physician for two (2) of fifteen (15) sampled residents (Residents #1 and #4). Resident #1 was observed to receive nectar-thick liquids with the noon meal on 10/21/14 and the evening meal on 10/22/14. The resident had physician's orders to receive honey-thick liquids. Resident #4 was ordered to have ice cream with meals to increase caloric intake; however, observation of Resident #4's tray revealed ice cream was not provided to the resident during the evening meal on 10/22/14.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Dietary Order Communication Protocol," (undated) revealed Dietary orders and changes of any type that were to be provided by the Dietary Department were to be communicated in writing. Further review of the policy revealed when a physician's order was written changing a type of diet or liquid consistency it was to be written on a duplicate dietary communication order sheet and sent to the Dietary Department.</p> <p>1. A review of the medical record for Resident #1 revealed the resident was diagnosed with Dysphagia, Failure to Thrive, Loss of Oral Intake, and Stage IV Melanoma. Review of the</p>	F 367	<p>F 367 It is and was on the days of survey the policy of Berea Health Care Center that therapeutic diets must be prescribed by the attending physician.</p> <p>1) Resident #1's diet tray card was immediately changed by the Dietary Manager after it was noted that the liquid consistency (nectar) indicated on the tray card was not the liquid consistency (honey) which was ordered by the Physician.</p> <p>The Dietary Staff was re-educated about the importance of ensuring that Resident #4 receive her ice cream to assist in increasing her calorie intake.</p> <p>The State Registered Nursing Assistant (SRNA) who was feeding Resident #4 was in-serviced on the importance of comparing the meal that Resident #4 is being served to the dietary card to ensure accuracy.</p> <p>2) Tray cards of all residents receiving thickened liquids were compared to the physician orders to ensure that each individual resident is receiving the consistency of liquids as ordered by the Physician.</p> <p>The Dietary Staff was in-serviced on October 23, 2014 and November 6, 2014 concerning the importance of more closely observing tray cards as trays are prepared to ensure that all residents are receiving the diets that have been ordered by the Physician.</p> <p>The Nursing Staff was in-serviced on October 23, 2014 regarding the</p>	

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F 367	<p>Continued From page 13</p> <p>physician's orders dated July 2014, revealed an order for the resident to receive honey-thick liquids. Further review of the medical record revealed the resident was evaluated by Speech Therapy from 07/22/14 to 08/07/14 due to a request by the resident's family. The family requested the evaluation to see if the resident could tolerate thinner consistency liquids. According to the speech therapy evaluation Resident #2 coughed with all textures but coughing was more pronounced with nectar-thick liquids. Further review of the evaluation revealed honey-thick liquids was probably most appropriate for the resident at that time. Resident #1 had a change in condition, was admitted to the hospital on 08/25/14, and returned to the facility on 08/28/14 with an order to change the consistency of liquids the resident received to nectar-thick. Further review of the medical record revealed the resident had physician's orders dated 09/17/14 to change the liquids the resident was to receive back to honey-thick liquids. A review of the dietary communication order sheet dated 09/17/14 and signed by the Dietary Manager revealed the resident was to have honey-thick liquids.</p> <p>Observations of Resident #1's lunch meal tray on 10/21/14 at 11:45 AM and evening meal tray on 10/22/14 at 5:45 PM revealed the resident was served nectar-thick liquids with the meal. A review of the tray card for these meals revealed the resident's liquid consistency was listed as nectar-thick on the tray card.</p> <p>An interview conducted with the Dietary Manager on 10/23/14 at 11:20 AM revealed the Dietary Manager (DM) received dietary communication order sheets from the nursing units and entered</p>	F 367	<p>importance of comparing the tray card to the meal during set-up to ensure that each resident is receiving the diet ordered by the Physician.</p> <p>3) On an on-going monthly basis, the Dietary Manger will compare physician diet orders to the tray cards to ensure that all information on the tray cards is consistent with the physician orders. This will be done to ensure that all residents are receiving the diets (including the correct consistency of liquid) as ordered by the Physician.</p> <p>On an on-going basis, the Dietary Manager and Registered Dietician will observe the tray line to ensure that the Cook and Dietary Aide are following each individual resident tray card to ensure that all items indicated on the tray card are sent to the residents.</p> <p>On a weekly basis, the Unit Coordinators and Charge Nurses will observe the Nursing Staff to ensure that they are checking the tray cards as meals are being set up to ensure that residents are receiving the diets that have been ordered by the Physician. If at any time, an item has been left off a tray, the Nursing Staff will immediately notify the Dietary Department to obtain the missing item.</p> <p>4) As part of the Quality Assurance Program, on a monthly basis, the Quality Assurance Nurse will audit the tray cards and physician orders of residents who are receiving thickened liquids to ensure the correct consistency of liquid as ordered by the Physician is noted on the</p>	

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F 367	<p>Continued From page 14</p> <p>the orders in the computer to print the resident's dietary tray card. Further interview with the DM revealed she had received and signed the order for Resident #1 to have nectar-thick liquids on 09/17/14 but forgot to enter the information into the computer. According to the DM, no one checks to ensure the order is entered into the computer or that the tray card matches the physician's orders.</p> <p>2. Record review revealed the facility admitted Resident #4 on 12/18/12 with diagnoses that included Alzheimer's, Thyroid nodule, Diabetes Mellitus, Ischemic Cardiomyopathy, Insomnia, Anorexia of Alzheimer's, Anxiety, Psychosis with Delusions, and History of Depression. A Quarterly Minimum Data Set dated 07/22/14 revealed Resident #4 was assessed as totally dependent on staff for activities of daily living with a Brief Interview for Mental Status (BIMS) score of 3, revealing severe cognitive impairment. Record review of October 2014 physician's orders revealed Resident #4 to have additional dietary orders of ice cream with lunch and supper to add calories.</p> <p>Record review of Resident #4's comprehensive care plan dated 10/20/14 and the Nursing Assistant Care Plan and Flow Record dated September 2014 to November 2014 revealed the resident was to receive ice cream with the lunch and supper meals.</p> <p>Observation on 10/22/14 at 5:10 PM, revealed SRNA #3 was assisting Resident #4 with the evening meal. The resident's supper tray contained no ice cream. Review of Resident #4's Dietary Card for the lunch and supper meals revealed the resident was to receive "ice cream</p>	F 367	<p>tray card. Any discrepancies found will be addressed immediately with the Dietary Manager.</p> <p>As part of the Quality Assurance Program, the Quality Assurance Nurse will audit meal trays weekly as they are being delivered to residents to ensure that those with orders for therapeutic diets are receiving the foods and/or beverage items ordered by the Physician. If a discrepancy is found, the Dietary Department will be notified.</p> <p>The above will be performed on a monthly basis and reviewed at monthly Quality Assurance Meetings.</p> <p>5) November 6, 2014.</p>	

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F 367	<p>Continued From page 15 with meal."</p> <p>Interview with SRNA #3 on 10/22/14 at 5:10 PM revealed Resident #4 had not received ice cream with his/her meal. SRNA #3 stated she was not sure if the resident was to receive ice cream on the supper tray. The SRNA read the certified nursing assistant care plan and stated it said ice cream. However, the SRNA said Resident #4 did not receive ice cream for supper on 10/22/14.</p> <p>Interview on 10/23/14 at 1:15 PM with the Dietary Manager revealed the last person to look at the tray should ensure accuracy before leaving the kitchen. The Dietary Manager said she did not know why Resident #4 did not receive the ice cream; she stated the resident was to receive it for lunch and supper.</p> <p>Interview on 10/23/14 at 3:00 PM with Licensed Practical Nurse (LPN) #1 revealed if a resident's meal does not include foods per the plan of care then the SRNA should inform her (LPN #1). The LPN said she would then call the kitchen and get what is needed.</p> <p>Interview on 10/23/14 at 2:30 PM with the Director of Nursing (DON) revealed if the SRNA noticed something on or not on the tray, she should notify the nurse to see if the order changed, and then the nurse should call Dietary.</p> <p>Interview on 10/23/14 at 10:15 AM with the Administrator revealed nursing staff needs to visually look at the diet card of residents when the meal tray first arrives on the floor.</p>	F 367			