

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

PRINTED: 01/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/18/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	INITIAL COMMENTS Based on the facility's acceptable PoC, the facility was deemed to be in compliance on 12/18/2013 as alleged.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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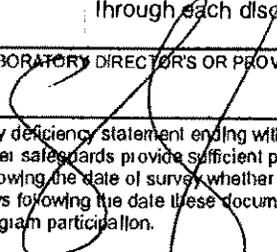
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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<p>F 000 INITIAL COMMENTS</p> <p>A Standard Recertification Survey was inflated on 11/19/13 and concluded on 11/21/13, with deficiencies cited at the highest scope/severity of a "D".</p> <p>F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for two (2) of nineteen (19) sampled residents (Residents #2 and #13). A review of the comprehensive plan of care for Residents #2 and #13, revealed staff would provide catheter care per the facility's protocol. A review of the facility's policy for inserting an indwelling urinary catheter revealed staff was required to secure the catheter to the resident's thigh (to prevent trauma). Observation of catheter care for Residents #2 and #13, revealed the indwelling catheters were not secured to the residents' thighs.</p> <p>The findings include: Review of the facility policy titled, "Care Plans", with a revision date of November, 2008, revealed the care plans identified needs of the resident through each disciplines assessment process</p>	<p>F 000 Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Lancaster of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Lancaster files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.</p> <p>Christian Care Center of Lancaster believes its current practices were in compliance with applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p>F 282</p> <p><u>Corrective Actions for Targeted Residents</u> Leg straps to anchor foley catheters for Residents #2 and #13 were applied by the Assistant Director of Nursing on 11/20/13 per facility protocol. SRNAs #3, #4, #5, #6, and RN #1 were educated by the Director of Nursing and Assistant Director of Nursing on 11/20/13 regarding the need for anchoring foley catheters to the resident's thigh via a leg strap for those resident utilizing indwelling catheters.</p> <p><u>Identification of Other Residents with Potential to be Affected</u> Current Residents utilizing foley catheters have the potential to be affected by this practice. Tubings were secured via a leg strap for remaining residents utilizing an indwelling catheter on 11/20/13 by the Assistant Director of Nursing, per facility protocol. Residents in the facility utilizing foley catheters will be visually checked by the assigned licensed nurse every shift to</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X8) DATE 12/23/13
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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 282 Continued From page 1
and would specify which disciplines would carry out the interventions. The policy also stated care plans would be located where they were easily accessible to all disciplines on all shifts.

Review of the facility's policy titled, "Foley Catheter Insertion and Removal", dated November, 1988, revealed staff was required to secure the indwelling urinary catheter to the thigh and attach to the drainage bag.

1. Review of the medical record revealed the facility admitted Resident #2 on 03/13/13, with diagnoses which included Chronic Skin Ulcer, Neurogenic Bladder, and Urinary Retention.

Review of a quarterly Minimum Data Set (MDS) assessment for Resident #2 dated 09/11/13, revealed the resident had been assessed by the facility to have severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of two (2). The MDS also revealed the resident required the extensive assistance of staff for toileting and was frequently incontinent of bowel.

A review of the physician's orders for Resident #2 revealed an order dated 04/02/13, for Resident #2 to have an indwelling urinary catheter due to the resident had a diagnosis of Neurogenic Bladder and Urinary Retention.

Review of the comprehensive plan of care for Resident #2 dated 04/02/13, revealed an intervention stating nursing staff would provide indwelling urinary catheter care per facility policy.

Observation of catheter care for Resident #2 by State Registered Nursing Assistant (SRNA) #3 and SRNA #4 on 11/20/13, at 10:25 AM, revealed

F 282 ensure that catheter anchors are secured to resident's thigh. This observation will be documented on the resident's Monthly Treatment Record every shift by same nurse.

Systematic Changes
When a new physician's order is received for placement of an indwelling catheter, facility protocol for catheter care will be transcribed onto the Treatment Record by the Licensed Nurse- to include anchoring of catheter tubing to the resident's thigh via a leg strap. This measure will also be enforced for newly-admitted residents presenting to the facility with an indwelling catheter in place- by the Admitting Nurse. Informal education with nursing staff on duty on 11/20/13 and 11/21/13 was conducted by the Director of Nursing and Assistant Director of Nursing. Additional education of all other nursing staff regarding the need to anchor foley catheters to the resident's thigh via a leg strap was conducted by the Director of Nursing on 11/21/13 and repeated on 12/12/13. Newly-hired nursing staff will be educated by the Assistant Director of Nursing regarding the need to anchor catheter tubings to the resident's thigh via a leg strap during their orientation period.

Monitoring
Audits for residents in the facility utilizing indwelling catheters will be conducted by unit supervisors monthly to ensure that catheter tubing is secured to the resident's thigh via a leg strap and that this intervention is documented on the Care Plan and the Treatment Record. The results of these audits will be presented monthly to the Performance Improvement Committee for review and recommendations by the Director of Nursing until 100% compliance are met for 3 consecutive months. The PI Committee consists of the Administrator, DON, ADON, Medical Director, Consultant Pharmacist, Maintenance Director, Dietary Supervisor, Social Services Director, Admissions Coordinator, Housekeeping/Laundry Supervisor, MDS Coordinator, HR Director, and Activities Director.

Date of Completion
12/18/13

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F 282 Continued From page 2

SRNA #4 draped the catheter over Resident #2's left leg. The SRNA's left the room and failed to secure the urinary catheter to the resident's thigh.

Interview conducted with SRNA #3 on 11/21/13, at 2:20 PM, revealed she was required to check the care plan daily for any changes. The SRNA stated if the resident had a leg strap to secure the urinary catheter already on she used it, and did not secure the urinary catheter if the resident did not already have a leg strap on.

Interview conducted with SRNA #4 on 11/21/13, at 2:30 PM, revealed she was required to check the care plan at the beginning of every shift. The SRNA stated she had been trained by the facility to place the urinary catheter tubing over the resident's leg and clip the catheter tubing to the pad underneath the resident. The SRNA stated she had never been told by the facility to attach the urinary catheter to the resident's thigh.

2. Review of the medical record revealed the facility admitted Resident #13 on 10/25/12, with diagnoses including Neurogenic Bladder and Urinary Retention.

Review of a quarterly MDS assessment for Resident #13, dated 10/30/13, revealed the resident had been assessed to be independent with decision making with a BIMS score of fourteen (14). The resident had also been assessed to require the extensive assistance of two (2) staff persons for toileting and was also assessed to be frequently incontinent of bowel.

Review of the physician's orders for Resident #13 revealed an order dated 11/09/13, at 11:00 AM for

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F 282	<p>Continued From page 3</p> <p>an indwelling urinary catheter to be inserted and staff were to provide catheter care every shift.</p> <p>Review of the comprehensive plan of care for Resident #13, revealed an intervention dated 11/09/13, for staff to provide catheter care per facility policy.</p> <p>Observation of catheter care provided for Resident #13 on 11/21/13, at 10:15 AM, revealed SRNA #5 draped the catheter over Resident #13's left leg. The SRNA's left the room and failed to secure the urinary catheter to the resident's thigh.</p> <p>Interview with Resident #13 on 11/21/13, at 10:30 AM, revealed the resident stated he/she did not remember the facility ever using a leg strap for his/her indwelling urinary catheter.</p> <p>Interview conducted with SRNA #5 on 11/21/13, at 2:35 PM, revealed she was required to review the resident's care plan at the beginning of every shift for any changes. The SRNA stated she was not sure why she did not use a leg strap to secure the urinary catheter.</p> <p>Interview conducted with SRNA #6 on 11/21/13, at 2:40 PM, revealed she was required to review the resident's care plan at the beginning of every shift for any changes. The SRNA stated she was not sure why she did not use a leg strap to secure the urinary catheter.</p> <p>Interview conducted with Registered Nurse (RN) #1 on 11/21/13, at 3:00 PM, revealed she was the Unit Manager for the HSC Unit of the facility. RN #1 stated staff were required to review the resident's care plans at the beginning of every</p>	F 282	

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F 282	Continued From page 4 shift to check for any changes. RN #1 stated she made rounds on the unit three (3) times daily to ensure residents were being provided the care and treatment as directed by their care plans. The RN stated the SRNA's were required to use leg straps. The RN stated she had not identified that staff were not using the leg straps as required. The RN stated she, "guessed I just did not look as closely as usual." Interview conducted with the Director of Nursing (DON) on 11/21/13 at 5:25 PM, revealed she made rounds throughout the facility several times a day to ensure residents were being provided the care and treatment as directed by the resident's care plans. The DON stated she had been unaware the facility policy stated urinary catheters would be secured to the resident's thighs. The DON stated she had not monitored to ensure indwelling urinary catheters were being secured, because she had not been aware indwelling urinary catheters should be secured to prevent trauma.	F 282			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	Christian Care Center of Lancaster believes its current practices were in compliance with applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: F 315 <u>Corrective Actions for Targeted Residents</u> Leg straps to anchor foley catheters for Residents #2 and #13 were applied by the Assistant Director of Nursing on 11/20/13 per facility protocol. SRNAs #3, #4, #5, #6, and RN #1 were educated by the Director of Nursing and Assistant Director of Nursing on 11/20/13 regarding the need for anchoring foley catheters to the resident's thigh via a leg strap for those resident utilizing indwelling catheters.		

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F 315 Continued From page 5
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure two (2) of (19) of nineteen sampled residents (Residents #2 and #13) received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. A review of the facility's policy for inserting an indwelling urinary catheter revealed staff were required to secure the catheter to the resident's thigh (to prevent trauma). However, observation of catheter care for Residents #2 and #13, revealed the indwelling catheters were not secured to the residents' thighs.

The findings include:

Review of the facility's policy titled, "Foley Catheter Insertion and Removal", dated November, 1988, revealed staff were required to secure the indwelling urinary catheter to the thigh and attach to the drainage bag.

1. Review of the medical record revealed the facility admitted Resident #2 on 03/13/13, with diagnoses which included Chronic Skin Ulcer, Neurogenic Bladder, and Urinary Retention.

Review of a quarterly Minimum Data Set (MDS) assessment dated 09/11/13, revealed the resident had been assessed by the facility to severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of two (2). The MDS also revealed the resident required the extensive assistance of staff for toileting and was frequently incontinent of bowel.

F 315 Identification of Other Residents with Potential to be Affected
Current Residents utilizing foley catheters have the potential to be affected by this practice. Tubings were secured via a leg strap for remaining residents utilizing an indwelling catheter on 11/20/13 by the Assistant Director of Nursing, per facility protocol. Residents in the facility utilizing foley catheters will be visually checked by the assigned licensed nurse every shift to ensure that catheter anchors are secured to resident's thigh. This observation will be documented on the resident's Monthly Treatment Record every shift by same nurse.

Systematic Changes
When a new physician's order is received for placement of an indwelling catheter, facility protocol for catheter care will be transcribed onto the Treatment Record by the Licensed Nurse to include anchoring of catheter tubing to the resident's thigh via a leg strap. This measure will also be enforced for newly-admitted residents presenting to the facility with an indwelling catheter in place- by the Admitting Nurse. Informal education with nursing staff on duty on 11/20/13 and 11/21/13 was conducted by the Director of Nursing and Assistant Director of Nursing. Additional education of all other nursing staff regarding the need to anchor foley catheters to the resident's thigh via a leg strap was conducted by the Director of Nursing on 11/21/13 and repeated on 12/12/13. Newly-hired nursing staff will be educated by the Assistant Director of Nursing regarding the need to anchor catheter tubings to the resident's thigh via a leg strap during their orientation period.

Monitoring
Audits for residents in the facility utilizing indwelling catheters will be conducted by unit supervisors monthly to ensure that catheter tubing is secured to the resident's thigh via a leg strap and that this intervention is documented on the Care Plan and the Treatment Record. The results of these audits will be presented monthly to the Performance Improvement Committee for review and recommendations by the Director of Nursing until 100% compliance are met for 3 consecutive months. The PI Committee consists of the Administrator, DON, ADON, Medical Director, Consultant Pharmacist, Maintenance Director, Dietary

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F 315	Continued From page 6 A review of the physician's orders for Resident #2 revealed an order dated 04/02/13, for Resident #2 to have an indwelling urinary catheter due to the resident had a diagnosis of Neurogenic Bladder and Urinary Retention. Observation of catheter care for Resident #2 by State Registered Nursing Assistant (SRNA) #3 and SRNA #4 on 11/20/13, at 10:25 AM, revealed SRNA #4 draped the catheter over Resident #2's left leg. The SRNA's left the room and failed to secure the urinary catheter to the resident's thigh. Interview conducted with SRNA #3 on 11/21/13, at 2:20 PM, revealed she had been trained to use a leg strap to secure the catheter to the resident's thigh, but stated she did not use a leg strap on all residents. The SRNA stated if the resident had a leg strap to secure the urinary catheter on she used it, and did not secure the urinary catheter if the resident did not already have a leg strap on. Interview conducted with SRNA #4 on 11/21/13, at 2:30 PM, revealed she had been trained by the facility to place the urinary catheter tubing over the resident's leg and clip the catheter tubing to the pad underneath the resident. The SRNA stated she had never been told by the facility to attach the urinary catheter to the resident's thigh. 2. Review of the medical record revealed the facility admitted Resident #13 on 10/25/12, with diagnoses including Neurogenic Bladder and Urinary Retention. Review of the physician's orders for Resident #13 revealed an order dated 11/09/13, at 11:00 AM for an indwelling urinary catheter to be inserted and for the staff to provide catheter care every shift.	F 315	Supervisor, Social Services Director, Admissions Coordinator, Housekeeping/Laundry Supervisor, MDS Coordinators, HR Director, and Activities Director. <u>Date of Completion</u> 12/18/13		

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F 315 Continued From page 7

Review of a quarterly MDS assessment for Resident #13, dated 10/30/13, revealed the resident had been assessed to be independent with decision making with a BIMS score of fourteen (14). The resident had also been assessed to require the extensive assistance of two (2) staff persons for toileting and was also assessed to be frequently incontinent of bowel.

Observation of catheter care provided for Resident #13 on 11/21/13, at 10:15 AM, revealed SRNA #5 draped the catheter over Resident #13's left leg. The SRNA's left the room and failed to secure the urinary catheter to the resident's thigh.

Interview with Resident #13 on 11/21/13, at 10:30 AM, revealed the resident stated he/she did not remember the facility ever using a leg strap for his/her indwelling urinary catheter.

Interview conducted with SRNA #5 on 11/21/13, at 2:35 PM, revealed she had been trained to use a leg strap to secure the catheter to the resident's thigh, but stated she did not use a leg strap on Resident #13 and should have. The SRNA stated she was not sure why she did not use a leg strap to secure the urinary catheter to prevent trauma.

Interview conducted with SRNA #6 on 11/21/13, at 2:40 PM, revealed she had been trained by the facility to place the urinary catheter tubing in a leg strap to secure the catheter and to prevent trauma. The SRNA stated leg straps were available, and should have been placed on Resident #13 prior to the SRNA leaving the room with SRNA #6.

F 315

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F 315	Continued From page 8 Interview conducted with Registered Nurse (RN) #1 on 11/21/13, at 3:00 PM, revealed she was the Unit Manager for the HSC Unit of the facility. RN #1 stated both Resident #2 and Resident #13 resided on the HSC Unit. RN #1 stated she made rounds on the unit three (3) times daily to ensure residents were being provided the care and treatment they required. The RN stated she checked all indwelling urinary catheters to ensure they were draining properly. The RN stated the SRNA's were required to use leg straps. The RN stated she had not identified that staff were not using the leg straps as required. The RN stated she, "guessed I just did not look as closely as usual." Interview conducted with the DON on 11/21/13, at 5:25 PM, revealed she made rounds throughout the facility several times a day to ensure residents were being provided the care and treatment they required. The DON stated the facility had not practiced securing indwelling urinary catheters, because she had not been aware that indwelling urinary catheters were required to be secured. The DON stated she had not monitored to ensure indwelling urinary catheters were being secured.	F 315		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514	Christian Care Center of Lancaster believes its current practices were in compliance with applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: F 514 <u>Corrective Actions for Targeted Residents</u> Activity attended by Resident #4 on 11/20/13 was documented on the Individual Resident Daily Participation Record that same day by the Activity	

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

PRINTED: 12/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF LANCASTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 9</p> <p>Information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to have an effective system to maintain activity records that were complete and accurately documented in accordance with accepted professional standards and practices for one (1) of nineteen (19) sampled residents (Resident #4). Resident #4 was observed at an activity on 11/20/13; however, it was not documented the resident attended the activity.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled, "Resident Activities 1.12 (Continued)", revised 09/08, revealed recordkeeping was part of the facility's activity program as it assisted with maintaining, planning, and developing the facility's activity programs. It further revealed the following records were maintained by the Director of Activities. These records included, the Activity Assessment, Resident Attendance Record, Calendar of Events, Activity Progress Notes, Individualized Activity Plan, Quarterly Assessments, Record of Review and Updates, and others as necessary and appropriate. The facility's policy stated the Director of Activities was responsible for obtaining, charting, and filing of required reports.</p>	F 514	<p>Director, Activity Director and Activity Assistant were educated on 11/21/13 by the Administrator regarding the need to document Resident participation in each activity.</p> <p><u>Identification of Other Residents with Potential to be Affected</u> Current residents in the facility have the potential to be affected by this practice. Facility Residents' Activity Participation Records were audited on 11/22/13 by the Administrator and the Activity Director to ensure accurate documentation of Resident Activities participation for the month was in place. Activity Director/Assistant Activity Director will complete the Individual Resident Daily Participation Record on a daily basis- immediately following the Activity.</p> <p><u>Systematic Changes</u> With current Activity Personnel educated, newly-hired employees working in the Activities Department will be educated by the Activity Director regarding the need to complete Individual Resident Daily Participation Records immediately after an Activity- during their Orientation Period.</p> <p><u>Monitoring</u> Residents' Individual Daily Participation Record for Activities will be audited weekly for 3 months by the Activity Director to ensure residents' participation in each activity has been accurately documented daily. The results of these audits will be presented monthly to the Performance Improvement Committee for review and recommendations by the Activity Director until 100% compliance are met for 3 consecutive months. The PI Committee consists of the Administrator, DON, ADON, Medical Director, Consultant Pharmacist, Maintenance Director, Dietary Supervisor, Social Services Director, Admissions Coordinator, Housekeeping/Laundry Supervisor, MDS Coordinators, HR Director, and Activities Director.</p> <p><u>Date of Completion:</u> 12/18/13</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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(X4) IO 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
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F 514 Continued From page 10

Record review revealed the facility admitted Resident #4 on 04/01/13, with diagnoses which included Dysphagia, Oropharyngeal Phase, Diabetes Mellitus, Alzheimer's Disease, and Essential Hypertension. On resident's most recent Minimum Data Set (MDS) quarterly, dated 10/02/13, resident had a Brief Instrument of Mental Status (BIMS) score of 01, which was indicative of being severely cognitively impaired. Review of residents care plan, dated 04/19/13, revealed activity staff were to inform the nurse for further evaluation if the resident had a change in the level of his/her activity. Review of resident's "Individual Resident Daily Participation Record", dated for the month of 11/13, revealed there was no documentation the resident attended an activity for 11/20/13. Further review of the facility's "Activities Attendance Sheets", dated 11/20/13, revealed the resident was not checked/highlighted for attending the scheduled activity.

Observation of Resident #4, on 11/20/13 at 10:00 AM, revealed the resident was sitting in his/her wheelchair in the front of the activity/dining room, to the far left of the room and to the far right of the speaker. Resident appeared to have enjoyed the singing as demonstrated by him/her smiling.

Interview with the Activities Director, on 11/21/13 at 3:20 PM, revealed her assistant had only recorded the Individual Resident Daily Participation Record every other day and agreed the report was not documented correctly. The Activities Director reported, however, she filled out the Activities Attendance Sheets, which should be correct, and resident's activity would be recorded into the Individual Resident Daily Participation Record from the Activity Attendance

F 514

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(X4) IO 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 514	Continued From page 11 Sheet. The Activities Director stated Resident #4 should have been recorded on the Activities Attendance Sheet for attending the scheduled activity. Interview with the Administrator, on 11/21/13 at 6:45 PM, revealed the Activity Director was responsible for documenting residents attendance to activities. He stated he received monthly reports from activities which reported activities residents have attended for the month. The Administrator added it should have been documented the resident attended the activity on 11/20/13.	F 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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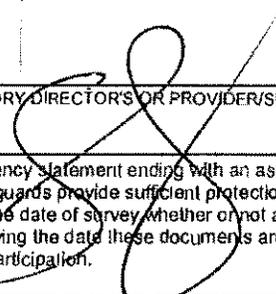
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 1 (332)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (WET SYSTEM)</p> <p>EMERGENCY POWER: Two Type II Diesel generators</p> <p>A life safety code survey was initiated and concluded on 11/21/13. Christian Care Center was found to be in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



ADMINISTRATOR

12/2/13

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.