

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

PRINTED: 07/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	RECEIVED AUG 2013 OFFICE OF MEDICARE GENERAL	(X3) DATE SURVEY COMPLETED  06/27/2013
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240		
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F 000	INITIAL COMMENTS  A recertification survey was conducted on 06/25/13 through 06/27/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E".	F 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy and procedure, it	F 280	The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.  <b>What corrective action will be accomplished for those residents found to have been affected?</b>  Resident #8's Plan of Care was revised on 6/27/13 to include resident's refusal of care and interventions and education to meet resident needs.  <b>How the facility will identify other residents having the potential to be affected by the same deficient practice?</b>  All residents were evaluated by Charge Nurse on each wing for preferences/refusal of care and Plan of Care updated to reflect preferences and care needs.	07/22/2013	

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

TITLE

(X6) DATE

*Frances M. Marko, CNHA*

*Administrator*

*8/7/13*

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.

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F 280	<p>Continued From page 1</p> <p>was determined the facility failed to develop and implement a care plan that appropriately addressed the needs of one (1) resident (#8), in the selected sample of twenty-one (21) residents, related to the refusal of care.</p> <p>Findings include:</p> <p>A review of the facility's Pressure Ulcers policy and procedure, last reviewed 09/2012, revealed a thorough skin assessment should be completed on admission and weekly for all residents.</p> <p>A record review revealed Resident #8 was admitted to the facility on 04/19/13 with diagnoses to include Aftercare Cholecystectomy, Muscle Weakness, Deconditioning, Difficulty with Ambulation, Late effects of Cerebral Vascular Accident, Left Hemiplegia, and Peripheral Vascular Disease (PVD).</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 04/16/13, revealed the facility assessed Resident #8's cognition was cognitively intact and the resident was at risk for the development of pressure sores, had two unstageable pressure sores on admission and had not refused care during the look back period.</p> <p>A review of the Comprehensive Care Plan for Risk for/Actual Impaired Skin Integrity, dated 04/17/13, revealed interventions for skin treatment per physicians orders and monitor skin during all activities of daily living (ADL) care for discoloration, edema, open areas, ulcerations, and temperature change.</p> <p>A review of a nurse's note, dated 05/20/13,</p>	F 280	<p><b>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</b></p> <p>Procedure for resident's Plan of Care has been updated to include: procedure for changes to be made to the Plan of Care with regard to resident's wishes including refusal of treatment.</p> <p>Staff reports any refusal of care to the charge nurse for that resident. Charge Nurse updates care plans and NA assignment sheets for those residents to reflect changes in care interventions to meet needs and wishes.</p> <p>Resident's refusal of care will be noted on the 24 hour report.</p> <p>Director of Nursing and/or Assistant Director of Nursing/Staff Development Coordinator provided in service education to all nursing staff regarding: a) staff report of refusal of care and Licensed staff put on 24 hour report; b) changes in Care Plan Procedure - Licensed staff to update care plan with interventions; and c) resident education provided to meet resident needs and include resident wishes.</p>	

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F 280	<p>Continued From page 2</p> <p>revealed Resident #8's heels were red with dry skin and the left heel had a crack to the left outer heel with a small amount of blood noted. A review of a physician's order, dated 05/20/13, revealed staff should apply Cuterin, Telfa, and Alleevyn to the resident's bilateral lower extremities (heels) and to change every three days and as needed.</p> <p>An observation of Resident #8's skin assessment and dressing change conducted by Licensed Practical Nurse (LPN) #1, on 06/26/13 at 9:00 AM, revealed Resident #8 had Alleevyn heel protectors over the socks when surveyor entered the room. The nurse removed the heel protectors and with much encouragement to the resident removed the resident's socks and conducted a skin assessment. The LPN identified an area on the left great toe tip which was identified by staff to be an unstageable ulcer and measured 1.9 centimeters (cm.) x 1 cm x 0 cm. The resident's heels were red, blanchable and mushy. The nurse reapplied the resident's socks and placed the Alleevyn heel protectors over the socks.</p> <p>An interview with LPN #1, on 06/26/13 at 10:55 AM, revealed she had changed the dressings to Resident #8's bilateral heels the previous day but did not remove the resident's socks to apply the dressing or conduct a skin assessment of the residents feet which was due that day because because the resident refused. She stated the resident liked to have the Alleevyn dressings placed over his/her socks and refused to have the socks removed. Additionally, LPN #1 revealed the Alleevyn dressing was probably not very effective over the resident's socks but the resident had the right to refuse to have his/her</p>	F 280	<p><b>How does the facility plan to monitor its performance to ensure that solutions are sustained?</b></p> <p>Unit Manager will monitor 24 hour report and care plans daily Monday through Friday to ensure changes are posted. The Weekend Supervisor will monitor the 24 hour report and care plans on Saturday and Sunday to ensure changes are posted</p> <p>Random audit of 2 resident care plans and 2 NA assignment sheets weekly by Assessment team (Consisting of all unit managers, Director of Nursing, and Assistant Director of Nursing) for compliance and results reported to QA team monthly for follow up and recommendations.</p>	

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F 280	<p>Continued From page 3 socks removed for the dressings.</p> <p>An interview with Registered Nurse (RN) #1, Unit Manager, on 06/27/13 at 10:02 AM, revealed she believed the Allevyn over the socks was not an effective treatment for Resident #8's heels but the resident refused to have the socks off for the dressing to be applied appropriately. The RN revealed the Certified Nurse Aides state the resident does not want his/her socks removed even for baths.</p> <p>Further review of the Comprehensive Care Plan, dated 04/17/13, revealed there was no care plan in place to address the resident's refusals to have his/her socks removed for bathing, skin assessments, or wound care.</p> <p>An interview with the Director of Nursing (DON), on 06/27/13 at 10:45 AM, revealed if the resident refused to have his/her socks removed then the nurse should attempt at a later time and explain to the resident the importance of looking at his/her feet to assess for any new or worsening areas. The DON stated a care plan for refusal of care should have been implemented.</p>	F 280		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p>	F 314	<p><b>What corrective action will be accomplished for those residents found to have been affected?</b></p> <p>Resident #8 had a skin assessment completed on 6/26/13 and new pressure relieving interventions for Lower Extremities implemented and added to Care Plan.</p>	07/22/2013

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F 314	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure their system to assess and identify pressures sores was effective and failed to ensure proper treatment and services to promote healing was provided for one (1) resident (#8), in the selected sample of twenty one (21) residents. The facility failed to revise the care plan for Resident #8 related to the resident refusing to remove socks so staff could conduct skin assessments to identify new pressure sores and provide treatment to pressure sores.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure titled, "Pressure Ulcers-Policy &amp; Procedure", dated August 2005, revealed the facility should "ensure that a resident who is admitted to the facility without a pressure ulcer does not develop a pressure ulcer unless clinically unavoidable and that a resident who has an ulcer receives care and services to promote healing and to prevent ulcers. A thorough skin assessment should be conducted on admission and weekly on all residents.</p> <p>A record review revealed Resident # 8 was admitted to the facility on 04/19/13 with diagnoses to include Aftercare Cholecystectomy, Muscle Weakness, Deconditioning, Difficulty with Ambulation, Late effects of Cerebral Vascular Accident, Left Hemiplegia, and Peripheral</p>	F 314	<p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice?</b></p> <p>All residents were evaluated by skin audit per Licensed staff for identification of new or worsening skin areas with Care Plan and treatments updated as indicated.</p> <p><b>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</b></p> <ol style="list-style-type: none"> <li>1. Nursing Assistant Assignment sheets will have area for daily notation of skin observations. (Ex. 1)</li> <li>2. Licensed Staff review assignment sheets by the end of each shift for any changes or skin observations.</li> <li>3. Licensed staff to complete a new skin assessment and update MD, care plan, treatment sheets and 24 hour Report as indicated.</li> <li>4. Pressure Ulcer Procedure updated to include changes in procedure.</li> <li>5. Weekly documentation of resident's skin condition by Licensed staff.</li> <li>6. DON and/or ADON/SDC provided education for all Nursing staff regarding changes in procedure.</li> </ol>	

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F 314	<p>Continued From page 5 Vascular Disease (PVD).</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 04/16/13, revealed the facility assessed Resident #8's cognition was cognitively intact and the resident was at risk for the development of pressure sores, had two unstageable pressure sores on admission and had not refused care during the look back period.</p> <p>A review of the Comprehensive Care Plan, dated 04/17/13, revealed a care plan for Risk for/Actual Impaired Skin integrity with interventions for skin treatment per physicians orders and to monitor skin during all activities of daily living (ADL) care for discoloration, edema, open areas, ulcerations, and temperature change.</p> <p>A review of a nurse's note, dated 05/20/13, revealed Resident #8's heels were red with dry skin and the left heel had a crack to the left outer heel with a small amount of blood noted.</p> <p>A review of a physician's order, dated 06/20/13, revealed staff should apply Cuterin, Telfa, and Allewyn to the resident's bilateral lower extremities (heels) and to change every three days and as needed.</p> <p>An observation of Resident #8's skin assessment and dressing change conducted by Licensed Practical Nurse (LPN) #1, on 06/26/13 at 9:00 AM, revealed Resident #8 had Allewyn heel protectors over the socks when surveyor entered the room. The nurse removed the heel protectors and with much encouragement removed the resident's socks and conducted a skin assessment. The LPN identified a new area to</p>	F 314	<p><b>How does the facility plan to monitor its performance to ensure that solutions are sustained?</b></p> <ol style="list-style-type: none"> <li>1. Unit managers monitor 24 hour report daily Monday through Friday and Week end Supervisor monitors 24 hour report Saturday and Sunday for skin issues and checks care plan for update as indicated.</li> <li>2. Random audit of 6 Nurse Aid Assignment sheets weekly for skin observations and Follow through per procedure to 24 hour report, MD notification and care plan. Results of audit reported to QA for follow up and recommendations.</li> </ol>		

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F 314	<p>Continued From page 6</p> <p>the left great toe tip which was identified by staff to be an unstageable ulcer. The area measured 1.9 centimeters (cm.) x 1 cm x 0 cm. The heels were red, blanchable and mushy. The LPN applied the resident's socks and placed Allevyn heel protectors over the socks.</p> <p>An interview with Resident #8, on 06/26/13 at 10:14 AM, revealed he/she knew about the new area to his/her left great toe for a couple of days but had not told anyone about it.</p> <p>An interview with LPN #1, on 06/26/13 at 10:55 AM, revealed she had changed the dressings to Resident #8's bilateral heels the previous day but did not remove the resident's socks to apply the dressing or conduct a skin assessment of the residents feet which was due that day because the resident refused. She stated the resident liked to have the Allevyn dressings placed over his/her socks and refused to have the socks removed. Additionally, LPN #1 revealed the Allevyn dressing was probably not very effective over the resident's socks but the resident had the right to refuse to have his/her socks removed for the dressings.</p> <p>An Interview with Registered Nurse (RN) #1, Unit Manager, on 06/27/13 at 10:02 AM, revealed she believed the Allevyn over the socks was not an effective treatment for Resident #8's heels but the resident refused to have the socks off for the dressing to be applied appropriately. The RN revealed the Certified Nurse Aides stated the resident does not want his/her socks removed even for baths.</p> <p>Further review of the Comprehensive Care Plan,</p>	F 314		

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F 314	Continued From page 7 dated 04/17/13, revealed there was no care plan in place to address the resident's refusals to have his/her socks removed for bathing, skin assessments, or wound care.  An interview with Certified Nursing Assistant (CNA) #1 on 06/26/13 at 11:27 AM, revealed she had seen the new area to the resident's left great toe on his/her shower day on 06/24/13 but did not report this to the charge nurse because she assumed nursing already knew about it.  An interview with the Director of Nursing (DON), on 06/27/13 at 10:45 AM, revealed she expected the nurses to conduct skin assessments weekly and to look for any changes to the resident's skin. The DON stated if the resident refused to have his/her socks removed then the nurse should attempt again at a later time and explain to the resident the importance of looking at his/her feet to assess for any new or worsening areas and to apply dressings as ordered.	F 314			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS  The facility must provide special eating equipment and utensils for residents who need them.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide adaptive equipment during the meal for one (1) resident (#23), not in the selected sample.  Findings include:	F 369	<b>What corrective action will be accomplished for those residents found to have been affected?</b>  Resident #23 received 2- 2 handled cups at her table with beverage pass in the dining room at each meal	07/22/2013	

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F 369	<p>Continued From page 8</p> <p>A record review revealed Resident #23 was admitted to the facility on 12/11/09 with diagnoses to include Anemia, Dementia, Organic Brain Syndrome, Late Effects of Cerebral Vascular Accident, and Parkinsons Disease.</p> <p>A review of the meal tray card for Resident #23 revealed the resident should have two double handled cups with each meal.</p> <p>Observation on 06/25/13 at 1:28 PM revealed Resident #23's meal tray had no two handled cup on the tray and on 06/27/12 at 01:30 PM there was only one two handled cup.</p> <p>An interview with CNA #1 on 06/27/13 at 1:30 PM revealed she tries to look at each tray card and ensure every thing on the card is on the tray. make sure the meal tray is according to resident get what is on them.</p> <p>An interview with the Dietary Manager, on 06/27/13 at 1:32 PM, revealed the two handled cups may not be coming back to the kitchen after the meals and the CNAs may not come to the kitchen and ask for one. She stated the person who sets up the cart should let her know whether or not there are enough cups for the resident's meal.</p> <p>An Interview with the Director of Nursing (DON),</p>	F 369	<p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice?</b></p> <p>All residents receiving adaptive eating equipment for meals have been identified on list for each wing and dining area to include required adaptive equipment. Resident's adaptive equipment has also been listed on meal card and Nursing Assistant Assignment sheet.</p> <p><b>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</b></p> <ol style="list-style-type: none"> <li>1. A list of residents with adaptive equipment will be provided on dining room beverage cart and to each wing by Dietary Manager.</li> <li>2. Adaptive Eating Equipment is listed on the resident's tray card and the Nursing Assistant Assignment sheet and on Beverage Cart for dining room.</li> <li>3. The list of Adaptive Equipment is updated by the Dietary Manager as changes occur.</li> <li>4. Dining services will provide adaptive equipment on trays and beverage cart.</li> <li>5. Tray line checker will double check for adaptive equipment on tray before serving resident.</li> </ol>	

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F 369	Continued From page 9 on 06/27/13 at 1:35 PM, revealed the trays should be looked at in the kitchen and compared to meal cards for accuracy and then the CNAs should look at the cards when passing the trays and report to the kitchen staff if anything is missing.	F 369	6. Director of Nursing and/or ADON/SDC and /or Dietary Manager provided education for Dietary employees and Nursing Assistants regarding: a) importance of adaptive equipment;		
F 371 SS=E	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. An observation of the kitchen, on 08/25/13, revealed liquid egg product in the refrigerator with no dates on the packages, spices on the shelf, estimated to have been three to four years old, baked-on, blackened debris on the drip tray, under the stove burners and a sanitizer bucket not having the recommended cleaning agent.  A review of the facility's census and condition, dated 06/25/13, revealed there were 105 residents in the facility with four of those residents being tube feeders and not utilizing the kitchen facilities.	F 371	7. b) new procedure for adaptive equipment lists and placement of adaptive equipment on beverage cart for dining room; c) double check for adaptive equipment by tray checker and Nursing Assistant.  How does the facility plan to monitor its performance to ensure that solutions are sustained? 1. Certified Nursing Assistant responsible for resident will check each meal for adaptive equipment before serving tray. 2. Dietary Manager will audit 5 meals/ week for presence of appropriate adaptive equipment and report results monthly to QA for follow up and recommendations.		

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240		
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F 371	<p>Continued From page 10</p> <p>A review of the facility "Food Labeling Policy," dated November 2008, revealed all food items that have been opened and not in their original cartons will be dated.</p> <p>Findings include:</p> <p>1. An observation of the refrigerator and freezer areas, on 06/25/13 at 8:45 AM, revealed eight bags of liquid egg product with no dates on the packages or the tray underneath.</p> <p>An interview with the Dietary Manager, on 06/25/13 at 9:00 AM, revealed the policy of the facility was the egg product was only to be kept for three days, after having been taken out of the freezer and the bags should have had a date on them.</p> <p>2. An observation of the kitchen, on 06/25/13 at 5:25 PM, revealed large bottles of Thyme, Sage, Oregano, Poultry Seasoning, Allspice and Lemon Pepper Seasonings with no dates on the containers.</p> <p>An interview with the Dietary Manager, on 06/25/13 at 6:00 PM, revealed those spices were not used very often and she thought several of these spices were obtained as much as four years ago, judging by the vendors label, as the facility had not used the vendor in four to five years. She also stated the spices were reordered, when they are emptied.</p> <p>3. An observation of the drip trays, under the stove burners, on 06/25/13 at 5:35 PM, revealed a thick build-up of blackened debris.</p>	F 371	<p><b>What corrective action will be accomplished for those residents found to have been affected?</b></p> <ol style="list-style-type: none"> <li>All bags of liquid eggs out of the original carton were labeled with product identification and a use by date on 6/26/2013.</li> <li>All spices are labeled with use by dates and out of date spices were discarded 6/26/2013.</li> <li>The drip tray under the burners on the stove was cleaned of blackened debris 6/25/2013.</li> <li>Sanitizer bucket poured out and refilled with quaternary sanitizer. 6/25/2013.</li> </ol> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice?</b></p> <p>Sanitation audit completed by Dietary Manager and corrections made for any items not labeled properly, any outdated foods, any dried food drips, and all sanitizer buckets were properly tested.</p> <p><b>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</b></p> <ol style="list-style-type: none"> <li>A new protocol for handling liquid eggs was initiated which requires labeling and dating each bag with use by date when out of carton.</li> </ol>	07/22/2013

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F 371	Continued From page 11  An interview with the Dietary Manager, on 06/25/13 at 5:45 PM, revealed the drip tray had not been cleaned since 06/17/13 and should have been cleaned weekly and as needed when spills were made.  4. An observation of the sanitizer buckets, on 06/25/13 at 6:00 PM, revealed there was no evidence of a cleaning agent on the test strip.  An interview with the Dietary Manager, on 06/25/13 at 6:05 PM, revealed the dietary staff member was using bleach in the bucket, instead of the recommended sanitizing agent and stated this should not have been used to clean the counters.	F 371	2. Labeling Procedure changed to specify that all spices will be labeled with a use by date per manufacturer's recommendation.  3. P.M. Cook (11:30) job duties were changed to add daily cleaning of the stove drip trays.  4. Dietary Manager and/or Registered Dietitian provided education for all Dietary employees regarding: a) use of proper sanitizer from pot and pan sink dispenser, b) changes in labeling procedure for spices; c) new protocol for labeling and use by date for liquid eggs removed from carton; and d) change in PM Cook (11:30) job duties to include daily cleaning of drip trays for the stove.  How does the facility plan to monitor its performance to ensure that solutions are sustained?  1. Dietary Manager to monitor daily cleaning of drip pan and report results to QA for follow up and recommendations.  2. Dietary Manager to complete Sanitation check of kitchen weekly and report results to QA monthly for follow up and recommendations.  3. Dietary Manager will audit 3 X per week labeling of liquid eggs and sanitizer bucket for compliance and report results monthly to QA for follow up and recommendations.		

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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: 1977.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1977, upgraded in 1998 with 102 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system installed in 1977.</p> <p>GENERATOR: Type II generator installed in 1977. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/25/2013. Christian Health Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for One-Hundred Fourteen (114) beds with a census of One-Hundred Five (105) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> 	

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

TITLE

(X6) DATE

*Frances M. Marko, CNHA*

*Administrator*

*8/17/13*

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.

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K 000	Continued From page 1 Fire).	K 000		
K 025 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, eighty (80) residents, staff and visitors. The facility is certified for One-Hundred Fourteen (114) beds with a census of One-Hundred Five (105) on the day of the survey. The facility failed to ensure three (3) smoke barriers have a ½ hour rating.</p> <p>The findings include:</p> <p>Observation, on 06/25/13 between 9:10 AM and 10:00 AM with the Maintenance Technician, revealed the smoke partitions, extending above</p>	K 025	<p><b>What corrective action will be accomplished for those residents found to have been affected?</b></p> <p>Smoke Barrier walls extending above room 201, 301, and 401 will have 5/8 " sheet rock applied over the exposed studs. The sheet rock shall be applied and sealed with tape and mud and have a 30 minute fire rating.</p> <p>The sheet rock will be applied by private contractor. (Ex 2)</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice?</b></p> <p>All Smoke barrier walls were inspected to ensure they are composed of material that meets the 30 minute fire rating.</p>	08/16/2013

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K 025	<p>Continued From page 2</p> <p>the ceiling located next to room #401, 301 and 201, were not properly sealed. The barriers were constructed with drywall on one side of the barriers and the framing studs exposed on the interior side of the barriers.</p> <p>Interview, on 06/25/13 between 9:10 AM and 10:00 AM with the Maintenance Technician, revealed he was not aware the barriers were not properly constructed to meet the ½ hour rating for a smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for</li> </ol>	K 025	<p><b>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</b></p> <p>Smoke barrier walls will be inspected after any installation or maintenance done in the attic. The inspection will be completed by maintenance technician and repair made as needed.</p> <p><b>How does the facility plan to monitor its performance to ensure that solutions are sustained?</b></p> <p>Smoke barrier walls will be inspected with quarterly building inspection to monitor barrier compliance. Compliance will be reported to QA committee quarterly for follow up and recommendations.</p>	

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K 025	Continued From page 3 the specific purpose.	K 025		
K 029 SS=D	<p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD Is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for One-Hundred Fourteen (114) beds with a census of One-Hundred Five (105) on the day of the survey. The facility failed to ensure five (5) rooms were properly protected due to the storage in the rooms.</p>	K 029	<p><b>What corrective action will be accomplished for those residents found to have been affected?</b></p> <p>The medical records office door has a door closer installed. The resident accounts office has a door closer installed. The human resources office has a door closer installed. The clean linen storage area in the laundry has a door closer installed. The activities storage closet has a self-closing door installed.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice?</b></p> <p>All offices inspected for excess paper storage and need for door closer. Additional door closers were installed</p> <p>In the nursing office, rehab office and activities office.</p>	08/16/2013

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K 029	<p>Continued From page 4</p> <p>The findings include:</p> <p>Observation, on 06/25/13 between 1:30 PM and 3:00 PM with the Maintenance Technician, revealed:</p> <ol style="list-style-type: none"> <li>1) The medical records office did not have a door closer installed due to the storage in the room.</li> <li>2) The resident accounts office did not have a door closer installed due to the storage in the room.</li> <li>3) The human resources office did not have a door closer installed due to the storage in the room.</li> <li>4) The clean linen storage area in the laundry did not have a door closer installed due to the storage in the room.</li> <li>5) The activities storage closet did not have a self-closing door installed due to the storage in the room.</li> </ol> <p>Interview, on 06/25/13 between 1:30 PM and 3:00 PM with the Maintenance Technician, revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in</p>	K 029	<p><b>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</b></p> <p>Offices will be monitored monthly for paper storage and door closers checked for compliance by maintenance technician.</p> <p><b>How does the facility plan to monitor its performance to ensure that solutions are sustained?</b></p> <p>Maintenance technician will report to QA monthly results of monthly monitor for compliance and recommendations.</p>	

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K 029	Continued From page 5 accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 056 SS=F	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water	K 056	K 056  What corrective action will be accomplished for those residents found to have been affected?  A sprinkler head will be installed in closets in rooms: 109, 110, 207, 208, 209, 210, 307, 308, 309, 310, 407, 408, 409, and 410 in addition to existing sprinkler heads in each room.  The sprinkler heads will be installed by private contractor (Ex 3)	08/16/2013

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K 056	<p>Continued From page 6</p> <p>supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Fourteen (114) beds with a census of One-Hundred Five (105) on the day of the survey. The facility failed to ensure fourteen (14) closets were properly sprinkler protected.</p> <p>The findings include:</p> <p>Observation, on 06/25/13 between 1:06 PM and 3:00 PM with the Maintenance Technician, revealed the closets of resident rooms #407, 408, 409, 410, 307, 308, 309, 310, 207, 208, 209, 210, 110, and 109 did not have proper sprinkler protection.</p> <p>Interview, on 06/25/13 between 1:06 PM and 3:00 PM with the Maintenance Technician, revealed he was unaware the closets were not properly sprinkled. The Maintenance Technician did not have any paperwork the closets were properly sprinkled.</p> <p>Reference: S&amp;C 09-04</p>	K 056	<p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice?</b></p> <p>An audit of closets in the building was completed by Maintenance Technician to ensure that closets are sprinkled.</p> <p><b>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</b></p> <p>No new closets will be constructed without proper sprinklers.</p> <p>The new sprinkler heads will be added to the monthly audit completed by Maintenance technician of sprinkler heads for lint and dirt and cleaned as indicated</p> <p><b>How does the facility plan to monitor its performance to ensure that solutions are sustained?</b></p> <p>Maintenance Technician will report to QA monthly on compliance of sprinkler audit and recommendations made as indicated.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185147	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  06/26/2013
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240		
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K 056	Continued From page 7 Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement <a href="http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-04.pdf">http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-04.pdf</a>	K 056			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for One-Hundred Fourteen (114) beds with a census of One-Hundred Five (105) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them. The deficiency was cited on the previous survey on 05/01/2012.  The findings include:  Observations, on 06/25/13 between 1:25 PM and 3:00 PM with the Maintenance Technician, revealed the electrical panels in the Electrical/Telephone room and in the Therapy storage room had storage within 3 feet of the electrical panels. The panels were blocked by boxes, tables, ceiling tiles, filters, wreaths, and chairs.	K 147	What corrective action will be accomplished for those residents found to have been affected?  Areas in front of the Electric panels in the Electrical Room and Therapy storage room were cleared of all items being stored there.  How the facility will identify other residents having the potential to be affected by the same deficient practice.  A Facility audit of electrical panels by Maintenance Technician to ensure that nothing is stored in front of panel.	07/22/2013	

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K 147	<p>Continued From page 8</p> <p>Interview, on 06/25/13 between 1:25 PM and 3:00 PM with the Maintenance Technician, revealed he was unaware of the storage in these areas. The Maintenance Technician was aware of this requirement as it was written on the previous survey.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110.26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p>	K 147	<p><b>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</b></p> <p>Areas in front of Electric Panels in Electrical/Telephone room and Therapy storage are clear of boxes, tables, ceiling tiles, filters, wreaths and chairs.</p> <p>A 3 foot area has been taped off on the floor with red caution tape in front of the electrical panels in Therapy room storage and Electrical/ Telephone room.</p> <p>Signs in RED stating "Do not place anything in front of panels in red taped area" were posted on panel doors.</p> <p>Staff Development Coordinator completed in service for all staff regarding no storage of items in front of the electric panels in Therapy storage and Electrical/Telephone rooms.</p>	

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K 147	<p>Continued From page 9</p> <p>Nominal Voltage to Ground      Minimum Clear Distance</p> <table border="0"> <tr> <td>Condition 1</td> <td>Condition 2</td> <td>Condition 3</td> </tr> <tr> <td>0-150 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>1 m (3½ ft)</td> </tr> <tr> <td>1.2 m (4 ft)</td> <td></td> <td></td> </tr> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.</p> <p>(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.</p> <p>(c) Existing Buildings. In existing buildings where</p>	Condition 1	Condition 2	Condition 3	0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600 mm (3 ft)	900 mm (3 ft)	1 m (3½ ft)	1.2 m (4 ft)			K 147	<p><b>How does the facility plan to monitor its performance to ensure that solutions are sustained?</b></p> <p>Environmental Services Director to Audit area weekly and report to QA monthly for follow up and recommendations.</p>	
Condition 1	Condition 2	Condition 3														
0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)														
151-600 mm (3 ft)	900 mm (3 ft)	1 m (3½ ft)														
1.2 m (4 ft)																

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K 147	Continued From page 10 electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices,	K 147		

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K 147	Continued From page 11 or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.	K 147		