

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| | | | | |
|--------------------|--|---------------|---|----------------------|
| (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

An abbreviated survey for KY20102 was initiated on 04/30/13 and concluded on 05/01/13. The Division of Health Care substantiated the allegation and deficiencies were cited.

An abbreviated survey was initiated and concluded on 05/01/13 for KY20079. The Division of Health Care unsubstantiated the allegation.

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:

F 000

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 the 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.

F 280

F 280

1. A comprehensive care plan was previously in place related to falls for resident #5. It stated "At risk for falls related to right hemiplegic requires assistance with transfers". On 5/1/13, this comprehensive care plan was updated to note the inclusion of a safety alarm to resident #5 bed and wheelchair. Subsequently, the above noted safety alarms were placed on resident #5 and the CNA care plan was updated to reflect the addition of resident #5 safety alarms.

2. The DON, Unit Manager, SDC and/or licensed nurse will review all resident care plans for completeness in accordance with their medical plan. Revisions of the care plans will be made as needed to ensure that it accurately reflect the specific resident's medical plan. All CNA plans of cares will be reviewed to ensure that all required adaptive equipment is incorporated into the plan of care.

6/13/13

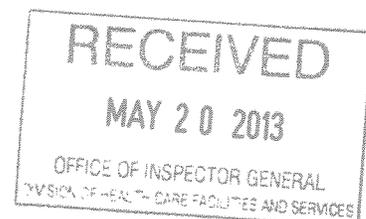
| | | |
|---|--------------------------------|-----------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> | TITLE <i>Administrative</i> | (X6) DATE 5/20/13 |
|---|--------------------------------|-----------------------------|

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

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 280 | <p>Continued From page 1</p> <p>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to revise the comprehensive plan of care for one (1) of the six (6) sampled residents (Resident #5) after the resident fell from the wheelchair.</p> <p>The findings include:</p> <ul style="list-style-type: none"> Review of the facility's policy regarding Care Plans, not dated, revealed the resident's care plan provides guidance to all staff caring for the resident and communicated changes in care to all direct care staff. The interdisciplinary care plan is reviewed, revised, and updated quarterly and more frequently if warranted by a change in the resident's condition. Review of the clinical record revealed the facility admitted Resident #5, on 04/06/13, with diagnoses of Depression, Hypertension, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease. On 10/31/12, the resident was found lying on the floor of the resident's room. The resident was sent to the hospital with complaints of leg pain and a hematoma to the head. The resident was subsequently diagnosed with a leg fracture. Interview with the Unit Manager, on 05/01/13 at 4:58 PM, revealed a low bed and bed/chair alarms were initiated to prevent further falls upon return to the facility. Further review of the resident's clinical record revealed the physician ordered an alarm on 11/26/12. Review of the comprehensive plan of care revealed the resident was at risk for falls | F 280 | <p>3. The CHC Consultant reviewed and revised the care plan policy and procedure on 05/14/13 (attachment 1). Our current system of reviewing and revising care plans will be changed to reflect the attached policy. The CHC Consultant will in-service the DON, Unit Manager, and SDC on the new care plan policy and procedure by 05/31/13. This in-service will include specific instruction on how to thoroughly update care plans (attachment 2). The CHC Consultant, DON, Unit Manager, SDC and/or licensed nurse will in-service all licensed nurses on the importance of care planning, checking the chart for new orders, and the removal of copies of orders from the chart. Removing copies of orders from the chart ensures that the DON, Unit Manager and/or SDC have timely access to them to review and update the care plan.</p> <p>4. The DON, Unit Manager, SDC and/or licensed nurse will audit 25% of all resident care plans monthly x 6 and report findings to the QA committee monthly for further review and recommendations.</p> <p>5. All corrective measures will be completed by 6/13/13.</p> | 6/13/13 | |



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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

F 280 Continued From page 2
related to right sided paralysis and required assist with transfers. The bed/chair alarms were not on the resident's comprehensive plan of care. Review of the Certified Nursing Assistant's (CNA) care plan revealed the bed/chair alarm was not listed.

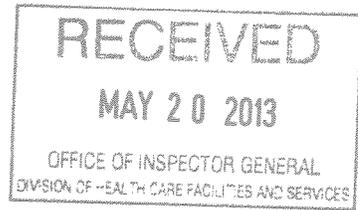
Observation of Resident #5, on 04/30/13 at 1:15 PM, 3:00 PM and 5:00 PM and on 05/01/13 at 7:50 AM, 10:00 AM, and 11:30 AM, revealed no bed or chair alarm was in place.

Interview with CNA #2, on 05/01/13 at 11:30 AM, revealed there was no type of alarming device listed for the resident on the CNA assignment sheet and she could not recall the resident ever having an alarming device.

Interview with Licensed Practical Nurse (LPN) #2, on 05/01/13 at 11:40 AM, revealed she could not remember if Resident #5 was to have an alarm and did not know if the resident was care planned to have them in place for safety. Observation of LPN #2 during interview revealed the nurse searching Resident #5's room, drawers, closet and not being able to locate any type of alarming device. Both CNA #2 and CNA #6 told the LPN they have never seen alarms on the resident's bed or chair.

Interview with the Unit Manager, on 05/01/13 at 11:51 AM, revealed the order for bed/chair alarms should have been caught upon the resident's return to the facility, in the morning meeting, or in the care conference. The Unit Manager revealed she was not monitoring to ensure orders were being transcribed over to the comprehensive plan and care and ensuring it was revised

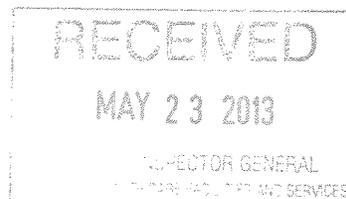
F 280



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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|--|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 280 | Continued From page 3 appropriately. The Unit Manager revealed a potential for the resident to fall and injure themselves again without the alarms in place. | F 280 | F323 1.The Administrator and DON re-opened the investigation of Resident #1 injury of unknown origin on 05/01/13. The investigation showed that no accidents occurred in the center that caused the injury to resident #1. Resident #5 was lowered to the floor while being transferred in a lift. Res #5 did not sustain any injuries as a result of being lowered to the floor. The SDC will in-service CNA #1 by 6/12/13 on the proper use of the CNA assignment sheet to ensure that Resident #5 has the proper equipment used at all times to aid in care delivery. A comprehensive care plan was previously in place related to falls for resident #5. It stated "At risk for falls related to right hemiplegic requires assistance with transfers". On 5/1/13, this comprehensive care plan was updated to note the inclusion of a safety alarm to resident #5 bed and wheelchair. Subsequently, the above noted safety alarms were placed on resident #5 and the CNA care plan was updated to reflect the addition of resident #5 safety alarms. | 6/13/13 | |
| F 323 | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure adequate supervision and assistive devices were used to prevent accidents. The facility failed to thoroughly investigate a fracture of unknown origin for Resident #1 and failed to investigate a fall involving Resident #5 from a lift during a transfer. The facility failed to place a safety alarm on Resident #5 that was ordered by the physician after a previous fall. The findings include: Review of the facility's policy regarding Accidents and Incidents, not dated, revealed all accidents or incidents must be investigated and reported to the Administrator within twenty-four (24) hours. Review of the facility's policy regarding | F 323 | 2. The DON, Unit Manager, SDC and/or licensed nurse will review incident reports of all residents currently residing in our center related to falls and/or injuries of unknown origin if applicable from 1/1/13 to 5/20/13 to ensure that all incidents have been thoroughly investigated and corrective measures have been/are implemented if applicable. | SBME | |



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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 280 | Continued From page 3 appropriately. The Unit Manager revealed a potential for the resident to fall and injure themselves again without the alarms in place. | F 280 | F323 | 6/13/13 | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure adequate supervision and assistive devices were used to prevent accidents. The facility failed to thoroughly investigate a fracture of unknown origin for Resident #1 and failed to investigate a fall involving Resident #5 from a lift during a transfer. The facility failed to place a safety alarm on Resident #5 that was ordered by the physician after a previous fall. The findings include: Review of the facility's policy regarding Accidents and Incidents, not dated, revealed all accidents or incidents must be investigated and reported to the Administrator within twenty-four (24) hours. Review of the facility's policy regarding | F 323 | 1. The Administrator and DON re-opened the investigation of Resident #1 injury of unknown origin on 05/01/13. The investigation showed that no accidents occurred in the center that caused the injury to resident #1. Resident #5 was lowered to the floor while being transferred in a lift. Res #5 did not sustain any injuries as a result of being lowered to the floor. The SDC will in-service CNA #1 by 6/13/13 on the proper use of the CNA assignment sheet to ensure that Resident #5 has the proper equipment used at all times to aid in care delivery. A comprehensive care plan was previously in place related to falls for resident #5. It stated "At risk for falls related to right hemiplegic requires assistance with transfers". On 5/1/13, this comprehensive care plan was updated to note the inclusion of a safety alarm to resident #5 bed and wheelchair. Subsequently, the above noted safety alarms were placed on resident #5 and the CNA care plan was updated to reflect the addition of resident #5 safety alarms. 2. The DON, Unit Manager, SDC and/or licensed nurse will review incident reports of all residents currently residing in our center related to falls and/or injuries of unknown origin if applicable from 1/1/13 to 5/20/13 to ensure that all incidents have been thoroughly investigated and corrective measures have been/are implemented if applicable. | | |

RECEIVED
MAY 20 2013
OFFICE OF INSPECTOR GENERAL

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| (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 323 | <p>Continued From page 4</p> <p>Mechanical Lifts, dated 08/2011, revealed all total mechanical body lifts would be loaded and unloaded with the use of 2 staff members. Nurses would complete a lift assessment and incorporate the findings into the care plan and the Certified Nursing Assistant assignment sheet.</p> <p>Review of the facility's policy regarding Falls Prevention, not dated, revealed the charge nurse would complete an incident/accident investigation to determine the root cause of a fall. Based on the findings, a new intervention would be added to aid in avoiding future falls. The interdisciplinary team would review the root cause analysis and any interventions implemented.</p> <p>Review of the clinical record revealed the facility admitted Resident #1, on 5/25/12, with diagnoses of Dementia, Stroke with Right Sided Paralysis, Depression, Congestive Heart Failure, Hypertension, and Aphasia (difficulty speaking). The facility assessed the resident utilizing the Minimum Data Set (MDS), dated 03/03/13, as having modified independence in cognition, and required extensive assistance in bed mobility, transfers, dressing, toileting, and hygiene. The facility assessed the resident as having clear comprehension, but rarely understood with communication.</p> <p>Review of Resident #1's clinical record revealed the facility transferred the resident to the hospital, on 03/25/13 after having difficulties with gastrointestinal bleeding. The facility readmitted the resident, on 04/01/13, receiving oxygen therapy and antibiotics for a urinary tract infection and pneumonia.</p> | F 323 | <p>3. The CHC Consultant will in-service the DON, Unit Manager, and/or SDC on the completion of incident reports (attachment 3). The CHC Consultant, DON, Unit Manager, and/or SDC will in-service all licensed nurses on the completion of incident reports. The DON, Unit Manager, SDC or licensed nurse will in-service all CNAs on the importance of the use of the CNA assignment sheets/care plans and the use of the correct lift per the assignment sheet/care plan. The SDC, Director of Risk Management and/or licensed nurse will in-service all nursing staff on the use of mechanical lifts to include return demonstrations (attachment 4). The Medical Records Coordinator and/or Unit Manger will ensure that incident reports are stocked on the unit daily to ensure that they are available for the licensed nurse's use.</p> <p>4. The DON, Unit Manager, SDC and/or licensed nurse will audit 100% of all incident report investigations weekly x 8, bi monthly x 2 then monthly x 2 to ensure all incident reports are thoroughly investigated. The DON, Unit Manager, SDC or licensed nurse will audit the placement of safety devices for all applicable residents 5 days weekly x 8, 3 days weekly x 8, then 1 x week x 8 weeks. The DON will report findings to the QA committee monthly for further review and recommendations.</p> <p>5. All corrective measures will be completed by 6/13/13.</p> | 6/13/13 |

RECEIVED
MAY 20 2013
 OFFICE OF INSPECTOR GENERAL
 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| (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 323 Continued From page 5
Interview with Licensed Practical Nurse (LPN) #6, on 04/30/13 at 1:45 PM, revealed the resident was having loose stool upon readmission from the hospital.

Continued review of the clinical record revealed nursing documentation, dated 04/03/13, which described the resident as restless but denied pain. On 04/04/13 the resident was crying out and continued to be restless, and on 04/06/13 swelling was noted to the left leg. An x-ray, dated 04/06/13, revealed a proximal left femur fracture and the resident was sent to the hospital.

Interview with LPN #3, on 04/30/13 at 1:30 PM, revealed Resident #1 was not verbal but could answer simple yes/no question and would shake their head yes or no as you went through the resident's body parts in an attempt to locate the source of pain.

Interview with LPN #6, on 04/30/13 at 1:45 PM, revealed the resident was restless and moaning, on 04/03/13, but when she would inquire about the source of the resident's discomfort, the resident either denied being in pain or patted their stomach.

Interview with Certified Nursing Assistant (CNA) #5, on 04/30/13 at 2:10 PM, revealed the resident was more sedate and yelled more frequently upon return to the facility on 04/01/13.

Interview with CNA #2, on 05/01/13 at 8:50 AM, revealed she was assigned to the resident on 04/04/13. The CNA revealed she was not told about any type of unusual occurrence involving Resident #1 on the previous day.

F 323

RECEIVED
MAY 20 2013
OFFICE OF INSPECTOR GENERAL
U.S. DEPARTMENT OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| | | | | |
|--------------------|--|---------------|---|----------------------|
| (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 323 Continued From page 6

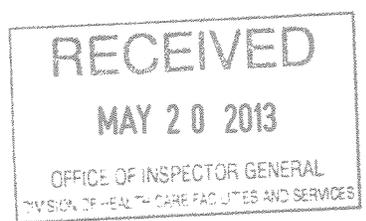
F 323

Interview with the Restorative Aide, on 04/30/13 at 2:40 PM, revealed Resident #1 had been having discomfort in the left leg since 04/02/13. The Restorative Aide stated she was unable to complete the assigned range of motion due to the resident's response and apparent discomfort. The Restorative Aide revealed she first visited the resident for range of motion the morning after he/she had returned to the facility. After informing the the assigned nurse of the resident's pain, the Restorative Aide revealed the resident then denied having leg pain and indicated having stomach discomfort.

Review of the facility's investigation revealed the nightshift nurse reported nothing unusual occurred on 04/03/13 or 04/04/13. The facility investigation revealed an agency CNA, who had been assigned to Resident #1, had used the wrong type of lift to transfer the resident and was forced to lower the resident to the floor on 04/03/13. The report described how the wrong family had been notified of the incident and documentation was placed in Resident #5's clinical record.

Interview with the owner of Accurate Staffing, on 04/30/13 at 4:43 PM, revealed the agency CNA had never been assigned to Resident #1 and had not even worked the hall in which the resident lived.

Interview with Registered Nurse (RN) #2, on 04/30/13 at 5:15 PM, revealed she was assigned as Resident #1's nurse on 04/03/13 and confirmed the agency CNA was not the resident's CNA and had in fact worked a totally different hall.



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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

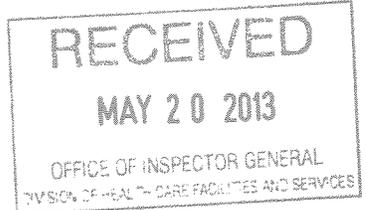
F 323 Continued From page 7
The RN revealed CNA #1 and CNA #4 worked with her that evening.

Interview with CNA #1, on 04/30/13 at 5:00 PM, revealed she was assisting CNA #4 get a resident up with a stand up Sara lift, when the resident could not bear weight and assist to stand, they lowered the resident to the ground. The CNA revealed the incident occurred on 04/03/13 and was on Resident #5, not Resident #1. The CNA revealed a statement as to what happened was given to RN #2.

Review of Resident #5's clinical record revealed the facility admitted Resident #5, on 04/06/13, with a diagnoses of Depression, Hypertension, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease. A comprehensive MDS assessment, dated 12/03/12, revealed the facility assessed the resident as interviewable with moderately impaired cognition and a Brief Interview for Mental Status (BIMS) score of 8. The Resident required extensive assistance with transferring, bathing, and dressing. Review of the CNA care plan revealed the resident was assessed as needing a maxi lift for transfers due the residents inability to bear their own weight or hold onto the handle bars.

Interview with RN #2, on 04/30/13 at 5:15 PM, revealed she was notified that a resident was on the floor. The RN revealed a CNA had used the SARA lift, which was the wrong type of lift for the resident, and explained how they misread the CNA assignment sheet. The RN revealed an assessment was completed and the resident was placed back to bed without any complaints of pain

F 323



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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

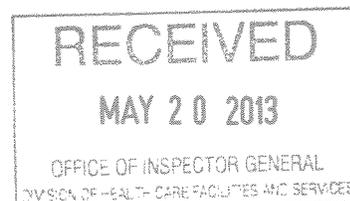
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

F 323 Continued From page 8
or discomfort. The RN revealed there were no incident reports available for use so the occurrence was documented in the resident's chart and both the family and the doctor were notified. The RN revealed this incident occurred with Resident #5; however, when the facility's Director of Clinical Services called the RN, she asked what had happened to Resident #1 and why was it documented on Resident #5's chart. The RN revealed the facility did not have an incident form available at the desk to fill out, therefore a statement was written and turned in to the Unit Manager. The RN revealed feeling confused by the call and could not understand why they felt the incident had been documented on the wrong person. After viewing photographs of both Resident #1 and Resident #5, the RN confirmed Resident #5 was the resident who fell and did not know why the Director of Clinical Services thought it was someone else. The RN revealed the incident was documented on the correct person and a statement was turned in to the Unit Supervisor. The RN revealed she did not know how Resident #1 sustained a fracture and was not told they had a fracture until the Director of Clinical Services told her during the phone conversation.

Interview with CNA #4, on 04/30/13 at 5:50 PM, revealed she did use the SARA standing lift to transfer Resident #5 instead of the Maxi lift. The CNA revealed she wrote a statement as to what happened and left it with the chart. The CNA revealed she was not aware any type of occurrences involving Resident #1 that would have caused a fracture.

Interview with Resident #5, on 05/01/13 at 7:50

F 323



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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

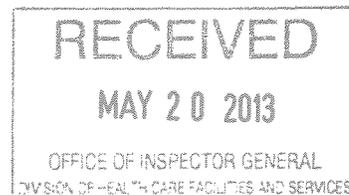
F 323 Continued From page 9
AM, revealed he/she was lowered to the ground after the facility staff attempted to get him/her up with a different type lift. The Resident revealed occurrence happened at the beginning of April.

F 323

Interview with the Unit Manager, on 05/01/13 at 8:30 AM, revealed she was called by the night shift nurse and told Resident #1 had a broken leg and that she thought she had fallen from a lift. The Unit Supervisor revealed notifying the Director of Clinical Services at that time. The Unit Manager revealed she had received a note from CNA #4, but did not turn it into the Director of Clinical Services till 05/08/13. The Unit Manager revealed an incident report was not filled out for Resident #1's fracture, or Resident #5's fall because she thought the Director of Clinical Services was doing both investigations.

Interview with the Director of Clinical Services (DCS), on 05/01/13 at 9:34 AM, revealed she was told Resident #1 had a fall that involved a lift. The DCS revealed she remembered someone talking about a note from a CNA, but never actually saw the note. The DCS revealed she did talk to RN #2 and assumed the RN knew which resident she was referring too during the conversation. The DCS revealed the RN did accurately describe the facility's staff that were involved with the actual fall; however, the DCS revealed she did not talk to Resident #5, CNA #1, or CNA #4 to confirm or deny which resident actually fell. The DCS revealed she should have interviewed all parties involved with both incidents to try and determine what had actually happened to Resident #1 and Resident #5.

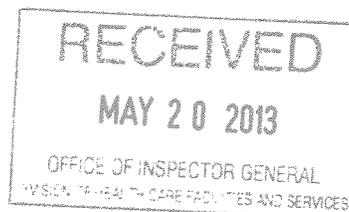
2. Further review of Resident #5's clinical record



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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 | | |
| (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 323 | <p>Continued From page 10</p> <p>revealed, on 10/31/12, the resident was found lying on the floor in the resident's room. The resident was sent to the hospital with complaints of leg pain and a hematoma to the head. The resident was subsequently diagnosed with a leg fracture. On 11/26/13, Resident #5's physician ordered safety alarms to bed and chair. Review of the resident's comprehensive plan of care and the CNA assignment sheet revealed safety alarms were not listed.</p> <p>Observation of Resident #5, on 04/30/13 at 3:00 PM and 5:00 PM, revealed no safety alarms were in place to either the wheelchair or the bed. Observations, on 05/01/13 at 7:50 AM, 10:00 AM, and 11:30 AM, revealed no alarms were in place to the wheelchair or the resident's bed.</p> <p>Interview with CNA #2, on 05/01/13 at 11:30 AM, revealed she normally worked with Resident #5 and did not remember there ever being any type of safety alarms.</p> <p>Interview with LPN #2, on 05/01/13 at 11:40 AM, revealed she did not know if Resident #5 was to have safety alarms and did not know if it was ever care planned. Observation of LPN #5 searching Resident #5's room revealed no alarm was found.</p> <p>Interview with CNA #6, on 05/01/13 at 11:43 AM, revealed safety alarms had never been in place for Resident #5.</p> <p>Interview with CNA #1, on 05/01/13 at 4:00 PM, stated she was Resident #5's routine CNA and had never seen an alarm of any type.</p> <p>Interview with Resident #5, on 05/01/13 at 4:10</p> | F 323 | | |



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

PRINTED: 06/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|--|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165488 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1016 MAGAZINE STREET LOUISVILLE, KY 40203 | | |
| (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 323 | Continued From page 11 PM, revealed there had not been any type of alarming device on either the bed or the wheelchair. Interview with the Unit Manager, on 05/01/13 at 11:51 AM, revealed she was not aware Resident #5's safety alarms were neither in place nor were they care planned. The Unit Manager revealed this should have been caught during care plan conference. The Unit Manager revealed she had not been monitoring to ensure safety devices were in place as ordered. | F 323 | | 6/13/13 | |
| 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 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to keep an accurate record of nursing documentation regarding the placement of safety alarms ordered by the physician for one (1) of the six (6) sampled residents (Resident #5). | F 514 | F 514 1. On 5/1/13, the comprehensive care plan was updated to note the inclusion of a safety alarm to resident #5 bed and wheelchair. Subsequently on 5/1/13, the above noted safety alarms were placed on resident #5 and the CNA care plan was updated to reflect the addition of resident #5's safety alarms. 2. The DON, Unit Manager and/or licensed nurse will review all resident medical status by 6/13/13 to determine if they need and/or have safety devices in place. 3. The DON, Unit Manager, and/or SDG will in-service all licensed nurses on the importance of accurate documentation to include signing the MAR/TAR after medication and treatment administration and after verification of placement of safety devices as appropriate. 4. The DON, Unit Manager and/or licensed nurse will audit the placement of all safety devices for applicable residents 5 days weekly x 8, 3 days weekly x 8, then 1 x week x 8 weeks. The DON will report findings to the QA committee monthly for further review and recommendations. 5. All corrective measures will be completed by 6/13/13. | By 6/13/13 - BME | |

RECEIVED
MAY 23 2013
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| (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 323 Continued From page 11
PM, revealed there had not been any type of alarming device on either the bed or the wheelchair.

Interview with the Unit Manager, on 05/01/13 at 11:51 AM, revealed she was not aware Resident #5's safety alarms were neither in place nor were they care planned. The Unit Manager revealed this should have been caught during care plan conference. The Unit Manager revealed she had not been monitoring to ensure safety devices were in place as ordered.

F 514 483.75(l)(1) RES
SS=D 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 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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review it was determined the facility failed to keep an accurate record of nursing documentation regarding the placement of safety alarms ordered by the physician for one (1) of the six (6) sampled residents (Resident #5).

F 323

F 514

1. On 5/1/13, the comprehensive care plan was updated to note the inclusion of a safety alarm to resident #5 bed and wheelchair. Subsequently on 5/1/13, the above noted safety alarms were placed on resident #5 and the CNA care plan was updated to reflect the addition of resident #5's safety alarms.

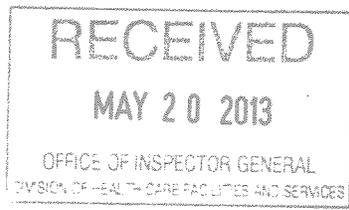
2. The DON, Unit Manager and/or licensed nurse will review all resident medical status by 6/13/13 to determine if they need and/or have safety devices in place.

3. The DON, Unit Manager, and/or SDC will in-service all licensed nurses on the importance of accurate documentation to include signing the MAR/TAR after medication and treatment administration and after verification of placement of safety devices as appropriate.

4. The DON, Unit Manager and/or licensed nurse will audit the placement of all safety devices for applicable residents 5 days weekly x 8, 3 days weekly x 8, then 1 x week x 8 weeks. The DON will report findings to the QA committee monthly for further review and recommendations.

5. All corrective measures will be completed by 6/13/13.

6/13/13



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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| | | | | |
|--------------------|--|---------------|---|----------------------|
| (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 514 Continued From page 12

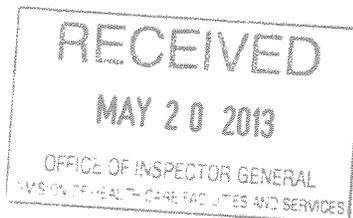
F 514

The findings include:

The facility did not provide a policy and procedure for clinical record documentation guidelines.

Review of Resident #5's clinical record revealed the facility admitted the resident on 04/06/13, with diagnoses of Depression, Hypertension, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease. A comprehensive MDS assessment, dated 12/03/12, revealed the facility assessed the resident as interviewable with moderately impaired cognition and a Brief Interview for Mental Status (BIMS) score of 8. The Resident required extensive assistance with transferring, bathing, and dressing. On 10/31/12, the resident was found lying on the floor of the resident's room. Review of the facility investigation revealed the resident fell from the wheelchair while attempting to self transfer. The resident was sent to the hospital with complaints of leg pain and a hematoma to the head. The resident was subsequently diagnosed with a leg fracture. On 11/26/13, Resident #5's physician ordered safety alarms to the residents bed and chair. Review of the resident's comprehensive plan of care and the CNA assignment sheet revealed safety alarms were not listed.

Observation of Resident #5, on 04/30/13 at 1:15 PM, 3:00 PM and 5:00 PM, revealed no safety alarms were in place to either the wheelchair or the bed. Observations, on 05/01/13 at 7:50 AM, 10:00 AM, and 11:30 AM, revealed no alarms were in place to the wheelchair or the resident's bed.



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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| (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 514 | <p>Continued From page 13</p> <p>Review of the Medication Administration Record (MAR), dated 04/01/13 to 04/30/13, revealed the facility's nurses had been signing the document indicating the alarms were in place.</p> <p>Interview with CNA #2, on 05/01/13 at 11:30 AM, revealed she frequently worked with Resident #5 and did not remember there ever being any type of safety alarms.</p> <p>Interview with LPN #2, on 05/01/13 at 11:40 AM, revealed she did not know if Resident #5 was to have safety alarms and did not know if it was ever care planned. Observation of LPN #5 searching Resident #5's room revealed no alarm was found.</p> <p>Interview with LPN #1, on 05/01/13 at 3:45 PM, revealed placing the nurses initials on the MAR indicated a medication was given or an order was completed. The LPN revealed she had signed the MAR indicating the alarms were in place. The LPN revealed she thought the alarms were ordered, but could not remember if they were actually in place.</p> <p>Interview with CNA #6, on 05/01/13 at 11:43 AM, revealed safety alarms had never been in place for Resident #5.</p> <p>Interview with CNA #1, on 05/01/13 at 4:00 PM, stated she was Resident #5's routine CNA and had never seen an alarm of any type.</p> <p>Interview with Resident #5, on 05/01/13 at 4:10 PM, revealed there had not been any type of alarming device on either the bed or the wheelchair.</p> | F 514 | | |
|-------|---|-------|--|--|

RECEIVED
MAY 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/01/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |
|--|---|

| (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 514 Continued From page 14
Interview with the Unit Manager, on 05/01/13 at 4:10 PM, revealed signing off on the MAR when the alarm was not actually in place was false documentation. The Unit Manager revealed every shift was responsible to actually look and ensure the safety alarms were in place before they ever signed the MAR. The Unit Manager revealed she was not monitoring documentation for accuracy.

F 514

RECEIVED
MAY 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE REGULATION AND SERVICES