

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

PRINTED: 09/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203	
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F 000	INITIAL COMMENTS	F 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/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 of federal and state law.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Care Plans, it was determined the facility failed to develop a comprehensive plan of care that included care and maintenance of a Peripherally Inserted Central Catheter (PICC) device for one (1) of two	F 279		

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

X Raymond A. D. S.

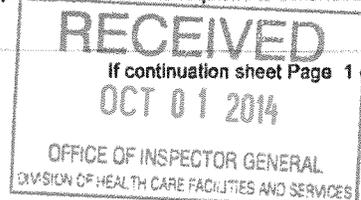
TITLE

Senior Executive Director

(X6) DATE

10/1/14

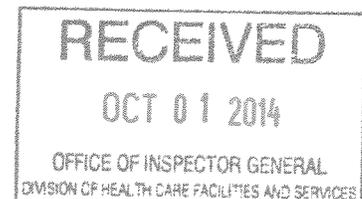
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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



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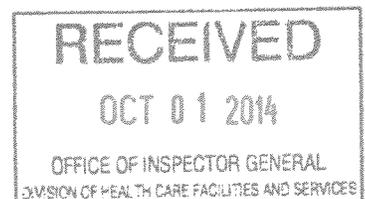
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F 279	Continued From page 1 (2) residents with PICC devices of the twenty-three (23) sampled residents, (Resident #13). The findings include: Review of the facility's policy titled Care Plans, revised May 2012, revealed comprehensive care plans would be completed within twenty-one (21) days of admission. The interim care plan could be converted into the comprehensive care plan by the Minimum Data Set (MDS) Coordinator's review to ensure all proceed to care plans were addressed and dated as comprehensive on the resident who was determined to be short term with discharge plans to return to home. The MDS Coordinator reviews the care plan with each MDS and updates as necessary and the Unit Mangers review the orders and clinical issues daily and updates the care plan as indicated with new or discontinued treatments and changes of conditions. Review of Resident #13's medical record revealed the facility admitted the resident on 07/31/14 and was transferred to the hospital from the Oral Surgeons office for acute care on 08/10/14 and was re-admitted to the facility on 08/15/14 with diagnoses of an Oral Infection, Chronic Pain, Gingival Recession, and post-surgical tooth extractions with administration of IV antibiotics. The resident was readmitted, with a PICC device for the IV antibiotic therapy. The facility assessed the resident using the Minimum Data Set (MDS), dated 08/07/14, as having a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. An initial care plan was developed on 07/31/14 and then developed into the	F 279	1) Resident #13's care plan was updated to include all care interventions on September 5, 2014 by the MDS Coordinator. 2) All assessments and care plans for residents residing in the facility for at least 21 days will be audited by October 10, 2014 by the MDS Coordinator to ensure the presence and completion of a comprehensive care plan. 3) The Director of Nursing (DON) will audit the care plans of all residents receiving PICC or IV therapy on a monthly basis to assure that all necessary assessments, care plan interventions and care protocols are present. The Unit Manager will also conduct an audit of a 10% sample of resident care plans to ensure the presence of a comprehensive care plan. The Unit Manager will provide the results of this audit to the DON. In addition, all licensed		



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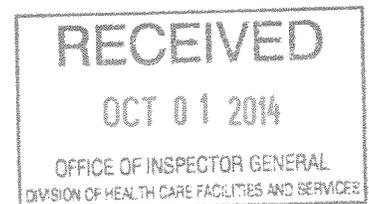
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F 279	<p>Continued From page 2</p> <p>comprehensive care plan on 08/07/14. The care plan for Resident #13 who was receiving IV Therapy for a facial abscess was developed and active on 08/28/14. The care plan included goals, and interventions for the PICC device. However, the care plan did not have an intervention to address the PICC device dressing changes, frequency or the discipline to perform the intervention. The care plan included an intervention for flushes as ordered with an active status; however, orders for PICC line flushes were not obtained until 09/05/14.</p> <p>Interview with License Practical Nurse (LPN) #5, on 09/05/14 at 10:35 AM, revealed he did not really look at the care plans, but knew the supervisor updated them. The nurse reviewed the care plan provided and stated there were no goals to address care and maintenance of the PICC device. LPN #5 stated the care and maintenance of Resident #13's PICC line should have been addressed on the comprehensive care plan.</p> <p>Interview with Unit Manager #2, on 09/05/14 at 10:15 AM, revealed the MDS nurses develop the comprehensive care plans. She further stated care plans could be updated and should have had interventions and goals to address the care and maintenance of the PICC device.</p> <p>Interview with Registered Nurse (RN) #3, on 09/05/14 at 1:30 PM to 2:00 PM, revealed the MDS nurses were responsible for the development of the comprehensive care plan for the facility residents and they could be updated by the Unit Managers. She stated the care plan addressed Resident #13's PICC device, but should have included an intervention for dressing</p>	F 279	<p>nursing staff were re-educated on the care associated with PICC and IV therapy lines by the Staff Development Coordinator on October 1, 2014. Lastly, the DON will re-educate the MDS Coordinators on the requirements for the timely completion of a comprehensive care plan on October 2, 2014.</p> <p>4) The DON submit a report of these audits for review by the Quality Assurance Committee on a monthly basis for 12 months and then as advised by the Quality Assurance Committee.</p> <p>Compliance Date: October 10, 2014</p>		



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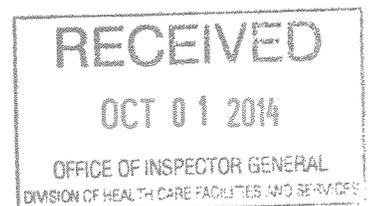
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F 279	Continued From page 3 changes and flushes. RN #3 stated after review of the resident's physician orders they did not include flushes or dressing changes and the orders and care plan should match. The nurse stated the care plan was reviewed and updated with each MDS assessment if needed. She further stated the resident's clinical record was reviewed, including all discipline notes along with the physician orders, she also interviewed direct care staff to get information on the resident's status and believed what happened was some of the care plan interventions were over looked and missed. Attempted Interview with Resident #13's physician, on 09/05/14 at 2:25 PM, revealed after a message was left with an answering service the request for a return call had not been received as of 09/19/14. Interview with Staff Development Nurse, on 09/05/14 at 2:10 PM, revealed after review of Resident #13's comprehensive care plan, the PICC device dressing changes and flushes were not addressed and should have been, therefore the facility did not provide all the care and services Resident #13 needed related to his/her PICC line. Interview with Director of Nursing (DON) on 09/05/14 at 2:30 PM, revealed she was still in orientation herself, but became aware the staff were not providing dressing changes or flushes for Resident #13's PICC line. The DON stated the care plan was not completed and the updated Care Area Assessments (CAA) and the clinical record did not mirror each other.	F 279			
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309			



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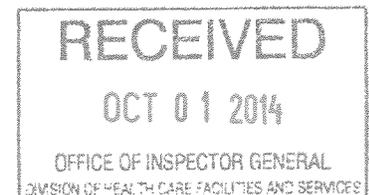
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F 309 SS=D	Continued From page 4 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the review of the facility's policies Dressing Changes for a Vascular Access Device and Flushing Technique Considerations, staff education and training records, it was determined the facility failed to provide dressing changes and flushes for one (1) of two (2) residents with Peripherally Inserted Central Catheter (PICC) devices of the twenty-three (23) sampled residents, (Resident's #13). The facility failed to ensure a PICC device received weekly dressing changes from 08/15/14 through 09/05/14 and failed to ensure the device was flushed according to policy. The findings include: Review of the facility's policy titled Dressing Change for Vascular Access Devices, dated 06/01/99, revealed dressing changes would be done at established intervals for vascular access devices (VAD). Transparent membranes dressing (no gauze over site) were to be changed every week and as needed (PRN) including applying a dressing labeled with the date and the	F 309	1) Resident #13's dressing was changed and PICC line was flushed on September 5, 2014 by the Unit Manager. 2) All residents that have a PICC or IV line were assessed by the Unit Manager on September 26, 2014 to ensure all dressing changes were compliant with the resident's plan of care. 3) All licensed nursing staff were re-educated by the Staff Development Coordinator on dressing change procedures for PICC and IV care on October 1, 2014. In addition, the Staff Development Coordinator will conduct a monthly audit of 4 PICC or IV line care procedures monthly to ensure the resident's dressing changes are current and compliant with the resident's plan of care. The Staff Development Coordinator will submit this audit to the DON for	



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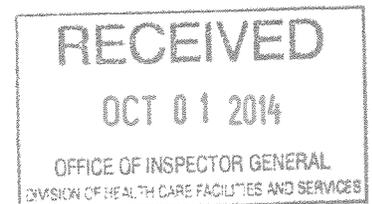
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F 309	Continued From page 5 nurse's initials. The policy did not address when the PICC lines valves were to be changed. Review of the facility policy titled IV (intravenous therapy) Flush Chart, revised (09/01/11), revealed PICC devices were to have a dressing change every seven (7) days, Central Venous Access Devices require a cap change before and after blood sampling and tubing and add-on devices changes every 96 hours. Review of the facility's policy titled Flushing Peripheral and Central Vascular Access Devices, dated 06/01/99, revealed all VADs would be flushed routinely when not in use to maintain patency and all VADs used for intermittent medication administration would be flushed. In addition, variations from recommended flushes were based on physician orders. Review of the facility policy titled IV (intravenous therapy) Flush Chart, revised (09/01/11), revealed a physician's or nurse practitioner's order was required for all flushes. In addition, PICC devices were to be flushed every eight (8) to twenty-four (24) hours and as needed for each lumen. Review of Resident #13's medical record revealed the facility admitted the resident on 07/31/14 to 08/10/14 with a transfer to an acute care facility from his/her Oral Surgeons office and was re-admitted to the facility on 08/15/14 with diagnoses of an Oral Infection, Chronic Pain, Gingival Recession, and post-surgical tooth extractions with administration of IV antibiotics. The resident was readmitted, with a PICC device for the IV antibiotic therapy. The facility assessed the resident using the Minimum Data Set (MDS), dated 08/07/14, as having a Brief Interview for	F 309	review. 4) The DON will submit this report for review by the Quality Assurance Committee on a monthly basis for 12 months and then as advised by the Quality Assurance Committee. Compliance Date: October 10, 2014	



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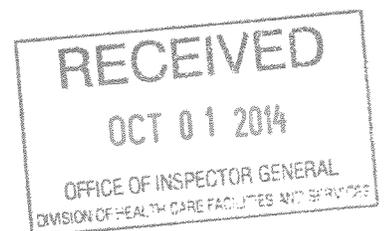
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F 309	<p>Continued From page 6</p> <p>Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.</p> <p>Review of prescriptions dated 08/13/14 and 08/15/14, written by medical staff at the acute care facility at discharge and delivered to the facility rehabilitation unit when Resident #13 was re-admitted to the facility, revealed written orders for an IV antibiotic, lab draws and line care.</p> <p>Review of Resident #13's physician order sheet for August and September 2014, revealed an order for Pfizerpen 20 million units intravenous with a continuous infusion every 24 hours at a rate of forty-two (42) cubic centimeters (cc) each hour for a total of forty-one (41) days with a stop date of 09/22/14. The resident's medication profile dated August 2014 did not include flushes or dressing changes for the PICC device per facility protocol nor was this information listed on the Order Reconciliation document from the re-admission on 08/15/14. The Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for August and September 2014 revealed no orders for PICC device dressing changes or flushes.</p> <p>Review of the Comprehensive Nursing Admission Assessment, dated 08/16/14, revealed Resident #13 had a PICC device and it was inserted on 08/13/14. Additional nursing notes revealed on 09/01/14 weekly labs were drawn from the PICC device and flushed per protocol. The facility was unable to provide any evidence the PICC device dressing changes or routine flushes had occurred.</p> <p>Observation of Resident #13's PICC device in his/her right arm, on 09/03/14 at 8:45 AM,</p>	F 309		



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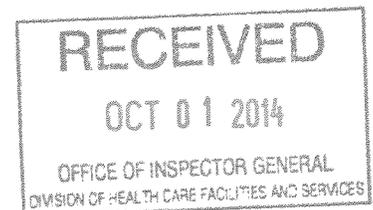
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F 309	<p>Continued From page 7</p> <p>revealed the transparent dressing covered the PICC device with a Biopatch (a small dressing containing Chlorhexidene) covering the insertion site with a double lumen, one for continuous infusion and the other was not in use. The hand written label on the dressing was initialed and dated 08/15/14. Additional observations on 09/03/14 at 9:35 AM, 11:35 AM, 2:25 PM, 3:45 PM; on 09/04/14 at 8:00 AM, 9:30 AM, 10:30 AM, 3:15 PM; on 09/05/14 at 8:15 AM, and during Resident #13's interview from 10:45 AM to 11:05 AM revealed the PICC dressing remained dated 08/15/14.</p> <p>Interview with Resident #13, on 09/04/14 at 3:15 PM, revealed his/her dressing covering the PICC device used for IV antibiotics had not been changed since returning to the facility on 08/15/14 and further stated the nurses had flushed the double lumen lines.</p> <p>Interview with LPN #5 on 09/05/14 at 10:20 AM to 10:35 AM, revealed he provided care to Resident #13 on 09/04/14 and 09/05/14 and did a visual inspection of the IV therapy and the IV site both days, and stated he saw nothing out of the ordinary; however, he was not aware of the date on the PICC dressing. LPN #5 stated a new order was written today, 09/05/14 for PICC device dressing changes every seven (7) days and flushes twice a day for Resident #13 and confirmed there were no orders for either prior to 09/05/14.</p> <p>Attempted Interview by phone, on 09/05/14 at 1:06 PM, with RN #5, who documented the flush on 09/01/14, revealed the phone was not answered and was unable to leave a message.</p>	F 309			



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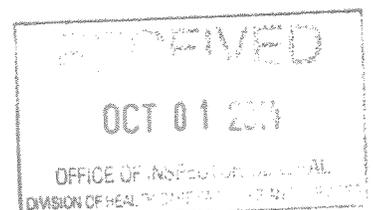
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F 309	<p>Continued From page 8</p> <p>Attempted Interview with Resident #13's physician on 09/05/14 at 2:25 PM, revealed after a message was left with an answering service the request for a return call was not received as of 09/19/14.</p> <p>Interview with Unit Manager #2, on 09/05/14 at 9:25 AM to 10:10 AM, revealed after reviewing Resident #13's clinical record no orders were written for the PICC device dressing changes or flushes. She reviewed the prescriptions from the hospital and stated the orders for line care should have been put into the computer as orders and then faxed to the pharmacy after the physician reviewed and approved the orders. Unit Manager #2 was not able to confirm the line care orders were put into the computer. Unit Manager #2 with the surveyor entered Resident #13's room at 10:00 AM to assess the date of the PICC dressing then exited the room and confirmed the date on the residents PICC dressing remained 08/15/14. She further stated the dressing change to the PICC was monitored by nursing staff every day and she was able to see the date on the label. There should not have been a delay, and the facility protocol was to change the dressing every seven (7) days and not doing so could increase the risk of infection for the resident. In addition she stated all staff had been trained on infection control, IV protocols, and taking orders off for the MAR's and TAR's.</p> <p>Review of the facility's training records, dated 01/10/14, revealed the content included IV insertion policy and procedure with demonstration on facility equipment which included handouts and discussion on the policy and procedures for PICC devices. The employee sign in sheets revealed Licensed Practical Nurse (LPN) #5 was</p>	F 309		



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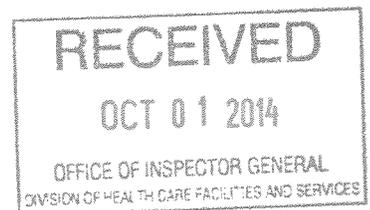
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F 309	<p>Continued From page 9 in attendance.</p> <p>Interview with Registered Nurse (RN) #3, on 09/05/14 at 1:30 PM to 2:00 PM, revealed she reviews all clinical documentation in the resident's chart and would determine the resident's needs and services based on that documentation. She confirmed after review of Resident #13's orders, that she was not able to identify orders for PICC line care, and stated Resident #13 was probably not getting the care and services needed. The nurse stated the outcome could have been possible infection.</p> <p>Interview with the Staff Development Nurse, on 09/05/14 at 2:10 PM, revealed she became aware that day of Resident #13's PICC device dressing dated 08/15/14. She confirmed the resident's line care was missed and the risk to the resident could be infection, and a blood clot to the line and possible non-function to the PICC device if not flushed. She stated facility staff had been provided with training and education on IV line care and maintenance and staff did not follow the facility policy and procedures. In addition the nurse did surveillance of facility staff, but IV therapy had not been something she had been watching. She stated she believed Resident #13's line care just got missed.</p> <p>Interview by phone with the facility's Pharmacist, on 09/05/14 at 2:00 PM, revealed she was not able to confirm if Resident #13's flushes, and dressing changes were on the medication profile and stated when residents were on IV therapy it was a standard for the pharmacy to supply all PICC line care items with the medication ordered by the physician.</p>	F 309			



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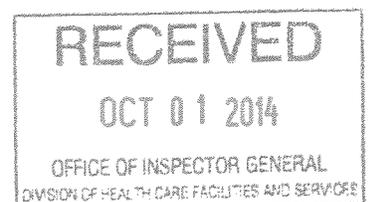
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2014
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F 309	Continued From page 10 Interview with Director of Nursing (DON), on 09/05/14 at 2:30 PM to 2:55 PM, revealed she was still in orientation herself, but became aware of the staff not providing Resident #13 with dressing changes to his/her PICC line. She further stated IV therapy services and care should have been provided to Resident #13. The DON stated she was surprised to hear about the dressing being dated 08/15/14 and stated the nurses failed to do their job.	F 309		
F 323 SS=D	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, and review of the facility's policy Medication Storage, it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible on one (1) of four (4) nursing units. A utility closet which contained hazardous biologicals and an unsecured ladder was observed unlocked on the Neighborhood Unit during the initial tour. The findings include: Review of the facility's policy regarding Medication Storage, undated, revealed	F 323	1) The supply closet was emptied on September 8, 2014 of all items and locked by the DON and Maintenance Director. The Maintenance Director installed a key pad lock on September 22, 2014 to ensure the closet door will remain locked each time it is shut after use. 2) There are no other supply closets in resident areas that are used in the same manner as the identified supply closet noted in the survey report. 3) The Maintenance Director and maintenance technician were educated on October 1, 2014 by the Senior Executive Director on the proper storage of ladders to	



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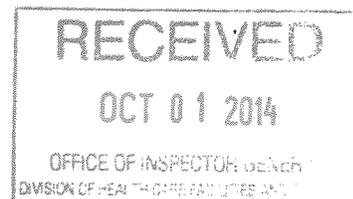
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F 323	<p>Continued From page 11</p> <p>medications were accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The policy further revealed medication rooms, carts, and supplies were to be locked or attended by persons with authorized access.</p> <p>Observation of the Neighborhood Unit, on 09/02/14 at 3:10 PM, revealed a supply closet door opening onto the main hallway and accessible to residents was unlocked. Further observation of the supply closet revealed storage of a six (6) foot ladder propped against the interior closet wall and numerous biologicals stored on a shelf. The biologicals observed stored there were forty-two (42) packets of nail polish remover, twenty-six (26) packets of Skin Prep protectant wipes, twenty-three (23) packets of Betadine/Povidone wipes, twenty-three (23) packets of Vaseline ointment, and forty (40) packets of Triple Antibiotic ointment.</p> <p>Interview with the facility's contracted pharmacy manager, on 09/04/14 at 11:45 AM, revealed ingested nail polish remover pads or povidone iodine swabsticks could potentially make a person sick. He further revealed the potential for harm was based upon the quantity ingested.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 09/04/14 at 10:55 AM, revealed the supply closet on the main hall of the Neighborhood Unit (a secure dementia unit) was to be locked at all times. The CNA further stated the assigned unit nurse held the key to unlock the closet door.</p> <p>Interview with CNA #2, on 09/04/14 at 11:00 AM, revealed there was no medication stored in the</p>	F 323	<p>allow the environment to be free of accident hazards as is possible. The Maintenance Director will conduct an audit monthly of this supply closet to ensure proper closure, securely locked and that no unapproved items are being stored.</p> <p>4) The Maintenance Director will submit this report for review by the Quality Assurance Committee on a monthly basis for 12 months and then as advised by the Quality Assurance Committee.</p> <p>Compliance Date: October 10, 2014</p>		



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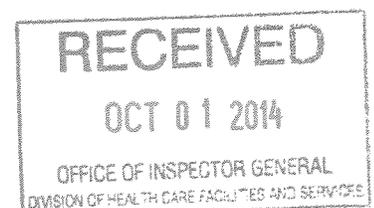
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F 323	<p>Continued From page 12</p> <p>Neighborhood Unit supply closet. The CNA stated only bandaids, Tegaderm and those types of supplies were stored in the closet.</p> <p>Interview with Registered Nurse (RN) #1, on 09/04/14 at 11:02 AM, revealed the unlocked supply closet posed a potential hazard to the residents on the Neighborhood Unit. RN #1 further revealed items stored in the supply closet could be ingested or used inappropriately if the door were unlocked and accessible to residents. In addition RN #1 stated the unsecured ladder stored in the closet could fall on a resident causing an injury and she further stated the supply closet was to be locked at all times.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/04/14 at 11:25 AM, revealed the Neighborhood Unit supply closet door was supposed be kept locked at all times. LPN #1 further revealed if the supply closet door were left unlocked a resident could get in the closet and get hurt. The LPN stated a resident could ingest a nail polish pad or skin prep and/or the ladder could fall on them. LPN #1 stated she was not aware supplies were stored in the closet.</p> <p>Interview with the Director of Nursing (DON), on 09/04/14 at 11:35 AM, revealed she was not aware of a supply closet on the Neighborhood Unit.</p> <p>Interview with the Administrator, on 09/04/14 at 2:55 PM, revealed the locked supply closet on the Neighborhood Unit had been set up a few months ago because there was no medication room on the unit. The Administrator stated the supply closet was to be locked at all times to protect the residents living there.</p>	F 323	
(X5) COMPLETION DATE			



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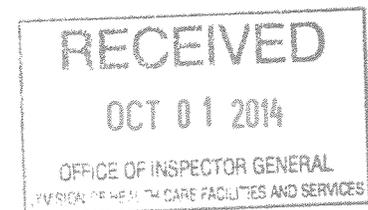
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F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>1) Resident #7 was re-assessed by the Unit Manager to ensure no signs or symptoms of infection were present on September 5, 2014. No signs and symptoms of infection were present for Resident #7.</p> <p>2) All residents receiving PICC or IV therapy were re-assessed by the Unit Manager on September 26, 2014 to ensure no signs and symptoms of infection were present.</p> <p>3) All licensed nursing staff were re-educated by the Staff Development Coordinator on infection control procedures for PICC and IV care on October 1, 2014. In addition, the Staff Development Coordinator will conduct a monthly audit of 4 PICC or IV line care procedures to ensure proper infection control practices are being utilized by the licensed nursing staff. The Staff Development Coordinator</p>



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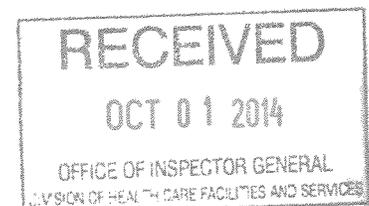
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F 441	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy Flushing Peripheral and Central Vascular Access Devices, it was determined the facility failed to ensure staff cleaned the lumen caps before administering medication through a PICC line for one (1) of two (2) residents with a PICC line of the twenty-three (23) sampled residents, Resident #7.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure for Flushing Peripheral and Vascular Access devices, dated 06/01/99, revealed the procedure was to maintain the patency of all peripheral and central vascular access devices. Step 6 indicted the staff was to scrub the needleless injection caps with alcohol prior to each entry. Step 10 stated staff was to scrub the needleless injection cap with alcohol and attach the Heparin flush syringe. Step 13 stated repeat for each individual lumen as needed.</p> <p>Observation during medication administration, on 09/03/14 at 10:10 AM, revealed Licensed Practical Nurse (LPN) #3 failed to cleanse the Peripherally Inserted Central Catheter (PICC) lumen with an alcohol-based preparation pad prior to the medication administration, for Resident #7.</p> <p>Interview with LPN #3, on 09/03/14 at 12:00 PM, revealed she was unaware of the omission of cleansing, but she knew the proper procedure for administering medication via a PICC port. Review of the employee training records, dated 09/04/14, revealed LPN #3 attended the training</p>	F 441	<p>will submit this audit to the DON for review.</p> <p>4) The DON will submit this report for review by the Quality Assurance Committee on a monthly basis for 12 months and then as advised by the Quality Assurance Committee.</p> <p>Compliance Date: October 10, 2014</p>



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F 441	Continued From page 15 for Infection Control. Interview with LPN #4, on 09/04/14 at 3:30 PM, revealed the standard of practice and the facility's policy/procedure for IV medication administration was that all caps accessed should be cleansed with an alcohol based preparation pad before medication administration. Interview with the Infection Control/Staff Development Nurse, on 09/04/14 at 2:45 PM, revealed Infection Control Inservices were done annually for all staff. More specifically all facility nurses were trained annually with written check-offs. However, that training was not included in nurse orientation. Interview with the Director of Nursing (DON), on 09/05/14 at 10:51 AM, revealed the correct procedure for IV medication administration was to include cleansing the caps with an alcohol based preparation pad before port access. Further interview with the DON revealed the importance of appropriate Infection Control IV PICC line practice was to prevent an increased spread of infection through the caps.	F 441			



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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: 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: Two (2) stories with a full basement, Type II Protected.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments on the first and second floors and three (3) in the basement.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet sprinkler system, hydraulically designed.</p> <p>GENERATOR: Type II, 155 KW generator. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was initiated on 09/03/14 and concluded on 09/04/14. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/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 of federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X* Raymond A. [Signature] TITLE *X* Senior Executive Director (X6) DATE *X* 10/1/14

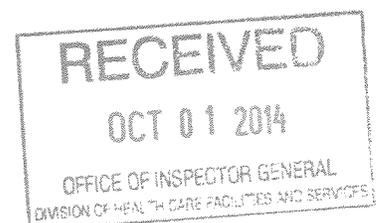
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

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If continuation sheet Page 1 of 5
OCT 01 2014
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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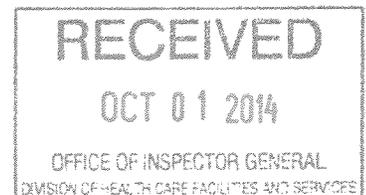
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K 000 K 029 SS=D	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved 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 for Protection of Hazards, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments on the second floor, approximately fifty (50) residents, staff and visitors. The facility has one-hundred and eighteen (118) certified beds and the census was one-hundred and eleven (111) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/04/14 at 8:52 AM, with the</p>	K 000 K 029	<ol style="list-style-type: none"> 1) The areas noted in the inspection report were patched with the fire rated sealant on September 17, 2014 by the Maintenance Director. 2) All of the 8 utility closets and 4 hopper rooms were audited on September 25, 2014 by the Maintenance Director. Any areas noted for non-compliance will be patched by October 1, 2014 by the Maintenance Director. 3) The Maintenance Director will conduct an audit monthly of all of the facility's 8 utility closets and 4 hopper rooms to assure their proper closure, locked securely and that no unapproved items are being stored. 4) The Administrator will review the audit report and submit this report for review by the Quality Assurance Committee on a 	



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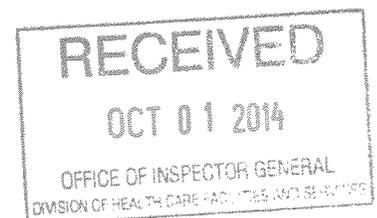
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K 029	<p>Continued From page 2</p> <p>Administrator and the Maintenance Director revealed the Utility Closet located in the second floor, B Wing had small openings in the interior walls where wall-mounted shelving had been removed. The openings had not been patched and sealed with a fire rated sealant and the room was not capable of resisting the passage of smoke in the event of an emergency.</p> <p>Interview, on 09/04/14 at 8:54 AM, with the Administrator and the Maintenance Director revealed they were not aware the small holes in the interior drywall had not been patched and sealed with a fire rated sealant. They acknowledged the room was not smoke-tight and capable of resisting the passage of smoke into the attic space in the event of an emergency.</p> <p>Observation, on 09/04/14 at 9:07 AM, with the Administrator and the Maintenance Director revealed the Hopper Room located in the second floor, A Wing had small openings in the interior walls where wall-mounted shelving had been removed. The openings had not been patched and sealed with a fire rated sealant and the room was not capable of resisting the passage of smoke in the event of an emergency.</p> <p>Interview, on 09/04/14 at 9:09 AM, with the Administrator and the Maintenance Director revealed they were not aware the small holes in the interior drywall were not patched and sealed with a fire rated sealant. They acknowledged the room was not smoke-tight or capable of resisting the passage of smoke into the attic space in the event of an emergency.</p> <p>The census of one-hundred and eleven (111) was verified by the Administrator, on 09/04/14. The</p>	K 029	<p>monthly basis for 12 months and then as advised by the Quality Assurance Committee.</p> <p>Compliance Date: October 10, 2014</p>	



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K 029	<p>Continued From page 3</p> <p>findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 09/04/14.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>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 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:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), 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. <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or</p>	K 029	
(X5) COMPLETION DATE			



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203		
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K 029	Continued From page 4 field-applied protective plates extending not more than	K 029			

