

RECEIVED

11-0-0 2013

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

PRINTED: 12/03/2013
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 11/01/2013
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	<p>INITIAL COMMENTS</p> <p>AMENDED 12/03/13</p> <p>An abbreviated and partial extended survey investigating KY20870 was initiated on 10/22/13 and concluded on 11/01/13. The Division of Health Care substantiated the allegation with Immediate Jeopardy and Substandard Quality of Care identified on 10/24/13 and determined to exist on 10/20/13. The facility was notified on 10/24/13 of the Immediate Jeopardy at 42 CFR 483.20 Resident Assessment (F280), 42 CFR 483.25 Quality of Care (F323), and 42 CFR 483.75 Administration (F490) with Substandard Quality of Care in the area of 42 CFR 483.25 Quality of Care (F323).</p> <p>On 10/20/13 at 5:37:21 (from the WanderGuard report) Resident #1 exited the facility without staff knowledge when the security guard entered an over ride code to open the front entrance door and allowed the resident to leave the facility. Resident #1 was found by a staff member ambulating on a sidewalk in front of a fast food restaurant 0.3 miles from the facility in a heavy traffic, four (4) lane street and was returned to the facility unharmed at approximately 8:29 AM on 10/20/13, approximately two (2) hours and fifty-two (52) minutes after he/she left the facility. Review of the National Weather Service archive temperature log revealed the temperature on 10/20/13 was 39 degrees Fahrenheit. Resident #1 was assessed by the facility as having no injuries.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 10/30/13 which alleged the Immediate Jeopardy was removed on 10/25/13.</p>	F 000	<p>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.</p> <p>F280</p> <p>1. At 7:30 am on 10/20/13, LPN #2 directed all staff on duty to conduct a facility wide search for resident #1 and took a census to ensure that all other residents were accounted for. Upon determining that resident #1 was not in the center, on 10/20/13, a licensed nurse notified the NHA, DON, police, physician, and Resident #1's responsible party. On 10/20/13, the DON and a licensed nurse completed a full body assessment on Resident #1 upon his return to the facility with a CNA # 4 at 8:29am. On 10/20/13, the DON checked Resident #1's wander guard for placement and functionality and the wander guard device worked appropriately. On 10/20/13, the Maintenance Director checked all exit doors for functionality and they were all noted to be operating appropriately.</p>	

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

TITLE

(X6) DATE

[Handwritten Signature]

Administrative

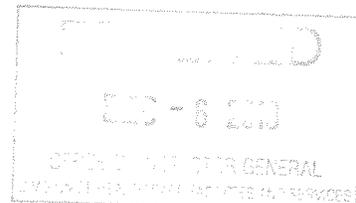
12/6/13

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

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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

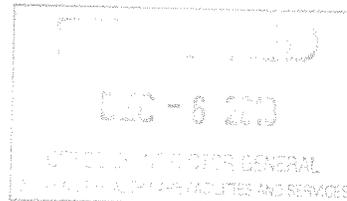
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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	Continued From page 1 The State Survey Agency verified Immediate Jeopardy was removed on 10/25/13 as alleged, prior to exit on 11/01/13 with remaining noncompliance at 42 CFR 483.20 Resident Assessment (F280), 42 CFR 483.25 Quality of Care (F323), and 42 CFR 483.75 Administration (F490) with Substandard Quality of Care in the area of 42 CFR 483.25 Quality of Care (F323). The scope and severity for F280, F323, and F490 were lowered to a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance program monitors the effectiveness of systemic changes to achieve and maintain substantial compliance.	F 000	On 10/20/13, the DON directed a licensed nurse to notify resident #1's responsible party and physician of his condition and safe return to the center. On 10/20/13, Resident #1's physician and/or ARNP ordered lab work. On 10/20/13, a licensed nurse reported the results of the lab work to the physician and/or ARNP and the results were noted unremarkable. On 10/21/13, Resident #1's physician completed an assessment of his condition and noted that Resident #1 was overall stable.		
F 280 SS=J	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.	F 280	On 10/20/13, the NHA and DON conducted a preliminary family meeting with resident #1's family members to inform the family of what the NHA and DON knew at present. On 10/20/13, the NHA and DON also scheduled a follow-up family meeting to be held on October 21, 2013 at 1:00PM to present more information. The NHA and DON initiated the investigation regarding resident #1 on 10/20/13 and completed it on 10/21/13.		



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

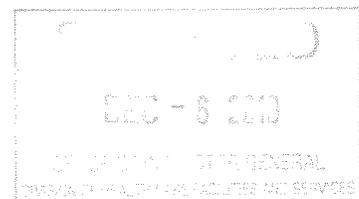
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review it was determined the facility failed to have an effective system to ensure the comprehensive care plans were reviewed and revised to address the frequency of monitoring residents who were identified by the facility as an elopement risk for one (1) of eight (8) sampled residents (Resident #1). The facility failed to revise the care plan for Resident #1 to ensure the staff were clearly directed on the frequency of resident checks for safety needs. On 10/20/13 at 5:37:21 (from the WanderGuard report) Resident #1 exited the facility without staff knowledge when the security guard entered an over ride code to open the front entrance door and allowed the resident to leave the facility. Resident #1 was found by a staff member ambulating on a sidewalk in front of a fast food restaurant 0.3 miles from the facility in a heavy traffic, four (4) lane street and was returned to the facility unharmed at approximately 8:29 AM on 10/20/13, approximately two (2) hours and fifty-two (52) minutes after he/she left the facility. Review of the National Weather Service archive temperature log revealed the temperature on 10/20/13 was 39 degrees Fahrenheit. Resident #1 was assessed by the facility as having no injuries. (Refer to F323) The facility's failure to ensure the care plan was reviewed and revised, placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment or death to a resident. The facility was notified of the Immediate Jeopardy on 10/24/13.	F 280	On 10/20/13, the DON reviewed resident #1's elopement assessment dated 10/20/13. The DON also spoke with direct care givers to determine alternative interventions for Resident #1. Resident #1's exit seeking care plan was revised by a licensed nurse with new interventions on 10/20/13 following his return to the building that included increased supervision of 1:1 supervision for 24 hours. At 7:15PM on October 20, 2013, the NHA and DON assigned a licensed nurse to complete a check on resident #1 and his CNA sitter every 15 minutes for the next 24 hours. On October 21, the NHA and DON directed the assigned, licensed nurse to check on resident #1 every 30 minutes for 24 hours. On 10/24/13, Resident #1's exit seeking care plan was reviewed and revised by the DON to include every two hour safety checks. Resident #1's comprehensive care plan was reviewed by a licensed nurse on 10/24/13 to ensure the care plans included all information contained on the C.N.A. Care plans. Resident #1's family was consulted on 10/25/13 by the DON to gather any further insight into appropriate interventions. On 10/25/13, Resident #1's family did not give the DON any further insight into appropriate interventions.	



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

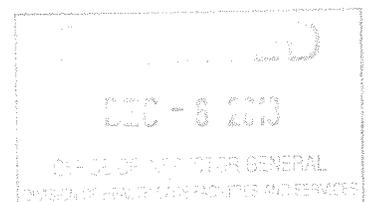
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/30/13 alleging Immediate Jeopardy was removed on 10/25/13. The State Survey Agency verified removal of Immediate Jeopardy on 10/25/13 as alleged, prior to exit on 11/01/13 with remaining non-compliance at a scope and severity lowered to a "D", while the facility develops and implements the quality assurance measures to establish and maintain an effective system to ensure care plans are revised to address the care needs of the residents. The findings include: Review of the facility's policy regarding Care Plans, revised 01/23/12, revealed the resident's care plan provided guidance to all staff caring for the resident and communicated changes in care to all direct care staff. The identified rule revealed under updating the care plan: the Interdisciplinary Care Plan was to be reviewed; revised; and updated quarterly and more frequently if warranted by a change in the resident's condition. Review of the facility's policy regarding Elopement, not dated, revealed through assessment, the staff were to identify residents at risk for elopement or unsafe wandering. The facility would enhance staff awareness of residents at risk and educate them in approaches/interventions for those residents. The procedure noted, at risk residents for Elopement/Wandering would be addressed on the care plan with individualized interventions. Patterns, if identified, and causes of this behavior would be addressed.	F 280	2. All 78 resident's elopement assessments were reviewed or reassessed by the DON, Unit Managers, Director of Clinical Support Services (DCSS), and the MDS Coordinator on 10/20/13. During the review on 10/20/13, the same 5 previously identified residents (Resident #1, #5, #6, #7, and #8) were assessed by a licensed nurse to be at risk for elopement. The DON checked and tested all resident wander guard devices for Resident #1, #5, #6, #7, and #8 for functionality and placement; which revealed that they worked appropriately on 10/20/13. On 10/20/13, the Maintenance Director checked all exit doors for functionality and they were all noted to be operating appropriately. Resident #1, #5, #6, #7, and #8 also had their exit seeking care plans reviewed and revised as needed based on the most current elopement assessment by the Director of Nursing on 10/20/13 and again on 10/24/13. Resident #1, #5, #6, #7, and #8 care plans also include supervision by nursing staff. All residents assessed to be at risk for elopement are monitored Q2 hours. Resident #1, #5, #6, #7, and #8 comprehensive care plans were reviewed by a licensed nurse on 10/24/13 to ensure the care plans included all information contained on the C.N.A. Care plans and were accurate as to care provided.		



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

PRINTED: 12/03/2013
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 11/01/2013
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 4 Review of the facility's investigation, dated 10/24/13, revealed on 10/20/13 Resident #1 exited the front door at the facility's entrance at 5:37 AM. The resident was returned to the facility at 8:29 AM, and was assessed with no injury. The physician and family were notified and elopement protocols were initiated. The root cause was determined to be Security Guard #6 thought the resident was a visitor and let the him/her out the front entrance. An interview conducted by the Administrator and the corporate Director of Clinical Services (DCS) with Security Guard #6 revealed the door did alarm when the resident approached the door; however, the security guard keyed in the over ride code to release the lock and let the resident exit the building. Review of the clinical record for Resident #1, revealed the facility initially admitted the resident on 11/29/12 and the facility assessed the resident as having a cognition score of four (4) on the Minimum Data Set (MDS) indicating a moderate impairment of cognition. Review of the physician orders dated 10/01/13 to 10/31/13 and the face sheet revealed diagnoses of Senile Dementia and Other Organic Psychotic Conditions. Review of the care plan, dated 01/28/13, for Resident #1 revealed the facility had identified the resident at risk for elopement due to the resident making statements of wanting to leave the building. The care plan identified the approaches as: the resident was to use a WanderGuard bracelet; the resident's picture would be displayed in the elopement book; approach the resident in a calm manner; redirect the resident to another location; walk with the resident in the direction he/she was going, then gradually assume	F 280	3. The DCSS reviewed and revised the Care Plan Revision Policy and Procedure on 10/24/13. The revisions included an example to increase staff understanding of when to update the plan of care. This example included continuing to add interventions when trying to alleviate unsafe behaviors. The DCSS educated the DON, and Unit managers on the revised Policy and Procedure on 10/24/13. The DON and Unit Managers verbalized understanding of care plan revision. A Unit Manager educated licensed nurses beginning on 10/24/13 in person and via phone on the revised Care Plan Revision Policy and Procedure. 11 nurses were educated in person and 13 via phone. The nursing staff educated verbalized understanding of the Policy and Procedure with discussion of examples, questions and answers and the use of a resident scenario attached to the revised Care Plan Revision Policy and Procedure.		



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

PRINTED: 12/03/2013
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 11/01/2013
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 5 leadership, direct the resident to an area of greater safety, and check WanderGuard placement every shift and function every week. The care plan did not give guidance to the staff on the frequency of checking the resident for safety related issues. Review of the Risk of Elopement/Wandering Review, revealed the resident was assessed on 01/28/13, 04/01/13, 06/10/13, and 09/10/13 for potential risk factors. Assessments dated 01/28/13 and 09/10/13 revealed the resident had verbally expressed the desire to go home and was exit seeking. Further review of the care plan revealed it did not direct staff as to how frequently to monitor the resident for safety related to the resident's exit seeking behavior. No guidance or direction to monitor the resident was identified in any of the resident's identified care areas. Interview with the Director of Clinical Services, on 10/24/13 at 3:55 PM, revealed it was the facility's standard of practice to monitor the residents every two hours. She stated it should have been identified in the incontinence care plan, at least. She reviewed Resident #1's care plan and stated there was no direction to monitor the resident every two hours; however, per interview staff should have revised the care plan to direct the staff in monitoring the resident every two hours. Telephone interview with CNA (Certified Nursing Assistant) #1 on 10/22/13 at 2:01 PM, revealed she was assigned to Resident #1 from 6:45 PM 10/19/13 to 7:00 AM on 10/20/13. The CNA stated the staff should check the residents every two (2) hours. Per interview she saw Resident #1 at 12:00 AM; however, she did not check on the resident again until 5:30 AM when she changed the resident, five (5) and a half hours later. She	F 280	On October 21, 2013, the NHA and DON directed all nursing staff that safety rounds must be conducted for all shift changes. On 10/21/13 the DON also re-educated all nursing staff on center procedures that direct a check of each resident every 2 hours at minimum. To ensure this standard of walking rounds at shift change is met, as of 10/21/13, the nursing staff must provide the DON a mutually-signed copy of the nursing staff member's care records for their shift daily. 4. The DON and/or Unit Managers will audit Care plans for correct revision 5 days weekly x 12 months based on new physician orders and assessment's completed from the preceding day. This will take place as a part of the daily clinical review meeting. Any needed corrections will be made at this time. The DON will review the findings of these audits with the NHA. The DON and/or Unit Manager will present the results of the audits to the Quality Assurance Committee monthly x 12 for further review and recommendation. The Senior Executive Director will review the QA minutes monthly and attend a QA meeting on a quarterly basis to monitor compliance. 5. All corrective measures will be completed by 11/27/13.	



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

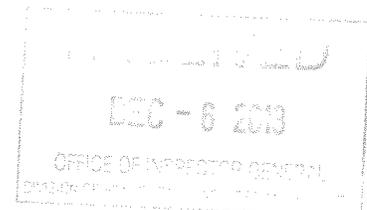
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 6</p> <p>further stated during the change of shifts, she and the on-coming staff were to do a physical walk around and report what was going on with each resident they were assigned. However, on 10/20/13 she had twenty-five (25) residents to care for and get up and the oncoming staff did not want to do a walking round report. The CNA stated she was aware the resident was an elopement risk and was exit seeking; however, checking residents every two (2) hours was not on the plan of care.</p> <p>Telephone interview with CNA #2, on 10/23/13 at 10:42 AM, revealed she was in the facility on 10/20/13 at 6:45 AM. She stated she was supposed to do a walk through with the off-going CNA; receive a report on each resident; and see each resident. However, a walk through was not conducted on 10/20/13 and CNA #1 had reported to her that everyone was fine. In addition, they were to round every two (2) hours on the residents. She stated she went to get Resident #1 up, about 7:30 AM and he/she was not in his/her bed. CNA #2 knew the resident was exit seeking and wanted to leave the facility. She stated the resident would have been identified as missing earlier if they had done the safety rounds as required.</p> <p>Telephone interview with LPN (Licensed Practical Nurse) #1, on 10/22/12 at 4:04 PM, revealed she had last seen Resident #1 during the end of her medication pass about 5:38 AM. The on-coming nurse declined to do a walk around because she was not feeling well. LPN #1 stated the frequency to check on the resident and/or shift change rounds was not on the care plan for Resident #1 even though she knew the resident was exit seeking and an elopement risk.</p>	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

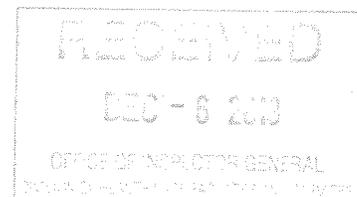
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 7 Telephone interview with LPN #2, on 10/22/13 at 3:25 PM, revealed she was the first shift nurse for Resident #1, the morning he/she had left the building. She stated they sometimes did a walking round with the off-going or on-coming staff; however, the morning the resident had left the building they did not do a walking round and she only received a verbal report. LPN #2 stated even though the resident was exit seeking, the care plan did not indicate every two hour checks or the shift change rounds to check on the resident. Interview, on 10/25/13 at 1:21 PM, with RN #2 the Minimum Data Set (MDS) Coordinator, revealed the Social Services staff completed the wandering section of the care plan assessments; however, the Social Services staff had recently resigned. She stated she reviewed the nurses notes or clinical documentation to support exit seeking behaviors for the care plan. However, she did not initiate the care plan for Resident #1 and could not state how the information was obtained for the assessment. Further interview revealed even though the care plan for Resident #1 did not say to monitor the resident, the residents should be checked every 2 hours. She stated there should be some direction in the care plan as to how staff were to monitor the resident and provide care. Interview with the Director of Clinical Services, on 10/24/13 at 4:10 PM, revealed the care plan was the tool used to inform staff of the resident's needed care and services. The nurses were responsible to update, revise, and develop the care plan as needed; however, the MDS staff were to initiate the care plan based on the Care	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

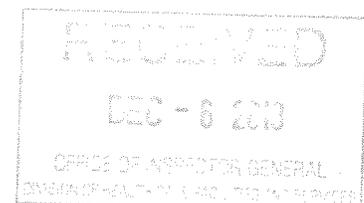
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 8</p> <p>Area Assessment (CAA) to include the monitoring of residents at risk for elopement.</p> <p>The previous Social Services staff was not available for interview.</p> <p>Review of the acceptable AOC revealed the facility took the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. A facility wide search and resident census was taken by the charge nurse immediately on 10/20/13 at 7:30 AM, to determine if Resident #1 was missing and all other residents were present. The Administrator, DON, police, physician and family of Resident #1 were all notified by telephone. 2. After Resident #1's return to the facility at 8:29:31 AM by CNA #4, the DON and LPN #2 assessed the resident. They assigned a LPN to complete a check on the resident and CNA sitter every fifteen (15) minutes for twenty-four (24) hours. On 10/21/13 the Administrator and the Director of Nursing (DON) directed the assigned staff to check on the resident every thirty (30) minutes for twenty-four (24) hours. 3. An investigation was initiated by the DON and the Administrator, on 10/20/13 at approximately 8:45 AM with interviews of staff on duty and telephone interviews with staff from the previous shift, and review of the video-surveillance tape. All exit doors were checked for functionality by the Maintenance Supervisor on 10/20/13 and all exit doors alarming appropriately. The DON notified the physician and assessed the resident along with LPN #2. 	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

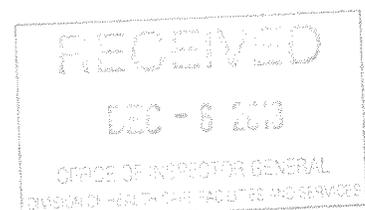
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 9 4. On 10/20/13, after review of the surveillance video revealed the Security Guard #6, had entered the bypass code and allowed Resident #1 to exit the building, unsupervised. The Administrator contacted the Security Agency to obtain contact information for Security Guard #6. The facility notified the Security Agency on 10/20/13 that effective immediately Security Guard #6 was no longer authorized to work at the facility. 5. On 10/20/13, after Resident #1's elopement from the facility, the Administrator determined the Security Communication binder and Elopement at Risk binder was in place and up-to-date as of 10/20/13 with all identifying information and a current photo in the binder for the five (5) residents (to include Resident #1) who had been assessed as being at risk for elopement. On 10/20/13 the DON checked the five (5) residents who had been assessed as being at risk for elopement with WanderGuard bracelets to ensure the bracelets' placement and functionality. The Administrator and the DON had identified the same five (5) at risk residents of the seventy-eight (78) residents assessed. The Director of Clinical Services, the DON, and RN #1 reassessed all seventy-eight (78) residents for their elopement risks on 10/20-21/13. 6. The Administrator and the Director of Clinical Services determined which security guards were scheduled to work from 10/20/13 and subsequent shifts and re-educated them on the policies related to elopement and completed a competency quiz with a score of 100% before allowing them to work any further shifts. The competency quiz was administered to all two (2) security guards scheduled to work by the DCS on	F 280		



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

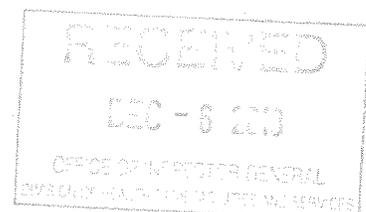
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 10 10/21/13. 7. A minimum of every two hour facility safety rounds were continued by the staff to ensure resident safety. Corrective action was issued to all nursing staff members with responsibility for caring for the resident during third shift on 10/19/13 and first shift 10/20/13; up to and including termination of employment. On 10/21/13 directives by the Administrator and DON and the QA Committee for all nursing staff that safety rounds must be conducted for all shift changes. To ensure this standard of walking rounds at shift change is met the nursing staff must provide the DON a mutually-signed copy of the staff member's care records for their shift. 8. All seventy-eight (78) resident's elopement assessments were reviewed or reassessed by the DON, Unit Managers, and the Director of Clinical Services, and reviewed on 10/20/13 the elopement assessments and care plans of the five (5) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct. In addition, all residents' admission assessments, care plans, CNA care records, assignment sheets, elopement, fall and smoking at risk assessments beginning on 10/20/13 and completed on 10/24/13 with revisions as indicated. 9. On 10/20/13 and 10/21/13, all current staff (with the exception of as-needed staff or those on an approved leave) were re-educated by a Unit Manager and the Director of Clinical Services on facility policies for: door alarm, door check, missing person, elopement, falls and smoking schedules for residents which included a post-test	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

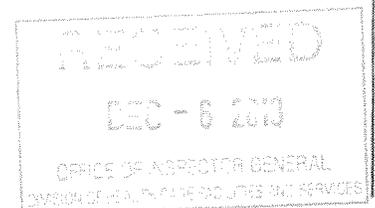
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 11</p> <p>to ensure competency. The Administrator assured as needed staff or those that were on approved leave were called via telephone on 10/20/13 to inform them that they were not to work any further shifts until they were trained on the policies and must meet with the supervisor at the beginning of a scheduled shift.</p> <p>10. On 10/21/13 the Administrator directed that a representative of the manufacturer of the Center's WanderGuard system be contacted for an onsite visit to re-check the functionality of all applicable doors and adjust the monitoring of sensitivity if needed. The testing and subsequent work was completed on 10/23/13 with the authorization to purchase an additional sensor on one interior door to heighten staff awareness to potential elopement in the corridor leading to the main entry door.</p> <p>11. The Administrator conducted a Quality Assurance meeting on 10/21/13 to review the investigation findings and actions taken by the facility. The QA meeting included the Administrator, Medical Director, DON, Unit Manager, and the Director of Clinical Services. Audits were developed and directives were given to ensure compliance. The Elopement at Risk binders would be audited weekly by the Unit Manager. Documentation of the correct placement and functionality of all WanderGuard devices in use would be audited weekly by a licensed nurse. Ten percent of the resident elopement assessments would be audited weekly by the Unit Manager or DON. The DON or Unit Manager would ensure the care plan would be reviewed and revised as needed to reflect if a resident was found to be at risk for elopement. The Maintenance Director would audit all exit</p>	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

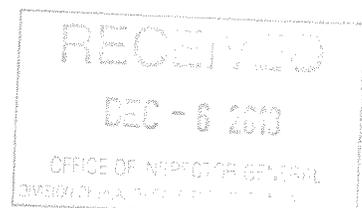
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 12</p> <p>doors for function with a WanderGuard four (4) times weekly. All staff responsible for conducting the audits was trained as of 10/21/13.</p> <p>12. All licensed nurses were educated on 10/21/13 by the DON that the WanderGuard computer monitor's volume level was not to be adjusted for any reason and was not to be turned off. The ability to change the monitor volume and the ability to turn the monitor on and off was disabled on 10/24/13 by the Senior Executive Director. The security staff would be audited three (3) times weekly by the Administrator on their competency and knowledge of the facility's door alarm and locking policy as well as all job-related requirements involving the use of the Elopement at Risk binder.</p> <p>13. All audits listed which were developed on 10/21/13 would be gathered by the Unit Manager weekly and submitted to and reviewed by the DON. The DON will report the findings of the audits to the Administrator. The Administrator will present the audit results to the Quality Assurance Committee monthly for twelve (12) months. The Senior Executive Director will review the Quality Assurance minutes monthly and attend the QA meeting on a quarterly basis to monitor compliance.</p> <p>14. The Unit Manager educated their total nursing staff of twenty-four (24) on 10/24/13 in person and via telephone on the revised Care Plan Revision Policy and Procedure. Unit Managers will audit care plans for correct revision five (5) days weekly based on new physician orders and assessment's completed from the preceding day. This will be a part of the daily clinical review meeting. Corrections needed</p>	F 280			



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

PRINTED: 12/03/2013
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 11/01/2013
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 13</p> <p>would be made at that time. The DON will review the findings of these audits with the Administrator who will present the results to the QA committee.</p> <p>15. The Senior Executive Director educated the Administrator on 10/24/13 of the Administrator's job responsibilities, duties and roles along with the company's Quality Assessment and Assurance policy to assure ongoing knowledge and performance of duties and responsibilities.</p> <p>The State Survey Agency validated through record review and interview the immediate Jeopardy was removed as follows:</p> <p>1. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed she was notified by the DON at approximately 8:00 AM by telephone on 10/20/13 of the elopement of Resident #1 after a facility wide search and determination Resident #1 was missing from the facility and immediate grounds. Interview with the DON, on 10/25/13 at 10:29 AM, revealed she was notified by RN #1 by telephone at approximately 7:50 AM on 10/20/13 of the elopement of Resident #1. Interview with RN #1, on 10/23/13 at 9:24 AM, LPN #2, on 10/22/13 at 3:25 PM, and LPN #3, on 10/23/13 at 2:12 PM, revealed they were directed to complete an accountability check for each resident on 10/20/13. Review of the nursing notes for 10/20/13 revealed the family and physician were notified by the DON at 8:50 AM.</p> <p>2. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed she had directed a nurse to complete a fifteen (15) minute check on the resident and CNA sitter</p>	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

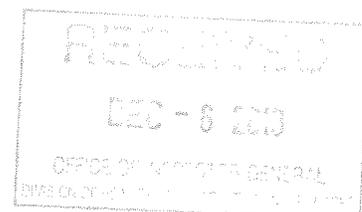
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 14 every fifteen minutes for twenty-four hours and then for staff to check the resident every thirty (30) minutes for twenty-four (24) hours. Review of the Check sheet dated 10/20/13 and 10/21/13, revealed staff monitored Resident #1 as directed. Review of the nursing documentation on 10/20/13, revealed LPN #2 documented the events from notification of resident missing to the resident's return and assessment completed. 3. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed an investigation was initiated by herself and the Director of Clinical Services. Review of the information gathered and documented interviews revealed the investigation had been initiated and was on-going. Review of the facility's investigation into Resident #1's elopement on 10/22/13, revealed staff interviews were done timely. Review of the Maintenance Supervisor report revealed all exit doors had been checked for function on 10/20/13 with no problems identified. 4. Review of the facility's video-surveillance tape and interview with Administrator, on 10/22/13 at 8:15 AM, revealed the Security Guard #6 had entered a bypass code at the front entrance (known as Main Street 2), on 10/20/13 at 5:37:21 AM, and allowed Resident #1 to exit the facility unsupervised. Review of the e-mail dated 10/23/13 from the facility to the Security Provider revealed the provider was informed of the termination of Security Guard #6 at the facility. 5. Record review and interview with the Administrator and the DON, on 10/22/13 at 8:15 AM, revealed they had checked the elopement at risk binder at the nursing station, on 10/20/13 to	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

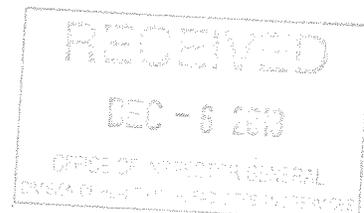
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 15</p> <p>ensure all identifying information and a current photo was in the binder for the five (5) residents (to include Resident #1) who had been assessed at being at risk for elopement. Review of the facility's elopement binder on 10/22/13 revealed all residents who were at risk for elopement had their identifying information in the Security Communication binder. Record review on 10/22/13 revealed seventy-eight (78) residents had been reassessed for their elopement risks by the DON, Director of Clinical Services, and Unit Managers. Review of the Maintenance door check lists revealed the doors were checked weekly without concerns identified. Review of the TARs revealed the WanderGuards were checked daily for placement and weekly for function.</p> <p>6. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed she had identified the security guards scheduled to work and immediately in-serviced them on the policy and procedures to include the Elopement at Risk binder. She stated a post-test was completed and they had to pass with 100 percent. Review of the post-test for Security Guard #5, revealed the test had been administered on 10/20/13 and Security Guard #9's test was administered on 10/21/13 with both scoring 100%.</p> <p>7. Record review and interview with the Administrator, on 10/24/13 at 3:30 PM, revealed corrective action was issued to LPN's #1 and #2, and CNAs #1 and #2 for failure to complete safety rounds as required. LPN #8 was terminated for turning off the computer monitor. Record review for the employees revealed the written reprimands were placed in the employee files, signed by the employees. Interviews with</p>	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

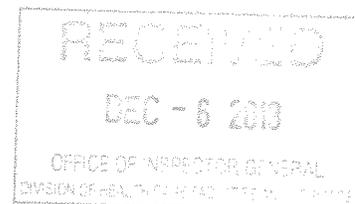
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 16 LPN # 8 revealed she had been terminated for turning off the computer monitor. Review of shift change walking rounds report completed by the LPN's at shift change on 11/01/13 revealed they were signed off by both staff indicating the walking round had been completed and all residents were accounted for. Interviews with CNA #5, on 10/31/13 at 12:50 AM, CNA #6, on 10/31/13 at 1:25 PM, LPN #1, on 10/22/13 at 3:57 PM, and LPN #2, on 10/22/13 at 3:25 PM, revealed the staff was to complete safety rounds at shift change and every two hours to ensure the residents were safe or if any care was needed. 8. Record review and interview with the Administrator and the Director of Clinical Services, on 11/01/13 at 11:00 AM revealed the DON, Unit Managers, Director of Clinical Services, and the Administrator had reviewed on 10/20/13, the elopement assessments and care plans of the five (5) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct with signatures and dates of the DON, Director of Clinical Services and Administrator. Interview with the Director of Clinical Services (DCS), on 11/01/13 at 11:00 PM, revealed the rest of the seventy-eight (78) residents' documents were reviewed with the Administrator and revisions were made as necessary. Review of the elopement assessments and care plans of the five (5) residents the facility had assessed as being at risk for elopement on 10/20/13 revealed signatures and dates of review and revision by the DCS, DON, and the Administrator. Additional review of all the resident's admission assessments and care plans, CNA care records, assignment sheets, elopement, fall, and smoking	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

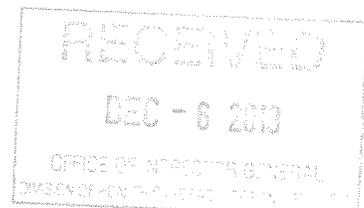
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 17</p> <p>at risk assessments began on 10/20/13 and completed on 10/24/13 were done.</p> <p>9. Record review and interview with the DON, on 10/25/13 at 10:29 AM, revealed she had provided the in-services regarding facility policies for: elopement risk/assessment; interventions; and steps to be taken during an incident of a missing resident; door alarms; door checks; falls; and smoking schedules; which included a post-test to ensure the staff's competency. Interview with CNA #5, on 10/31/13 at 12:50 AM, revealed she received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident, falls, door check, smoking policy, safety rounds, which included a post-test on 10/20/13. Interview with CNA #6, on 10/31/13 at 1:25 PM, LPN #1, on 10/22/13 at 3:57 PM, and LPN #2, on 10/22/13 at 3:25 PM, revealed they received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident falls, door check, smoking policy, safety rounds, which included a post-test to ensure competency on 10/20/13. All in-service training content and staff sign-in sheets were reviewed on 10/31/13 to ensure all nursing staff had been re-trained per the AOC.</p> <p>10. Record review and interview with the manufacturer's representative of the Center's WanderGuard system revealed an on-site visit was made to verify the function of all exit doors and adjust the monitoring of sensitivity. Interview with Representative, on 10/22/13 at 11:15 AM, revealed he was contacted by the Administrator on 10/20/13, of the resident elopement and the Maintenance Director was in the facility to check all exit doors. He stated he had checked all exit</p>	F 280			



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

PRINTED: 12/03/2013
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 11/01/2013
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 18 doors on 10/21/13 and they were working appropriately. He stated the inner door was working and he had added an extra sensor. He stated the inner door was not an exit; however, it was to make staff aware of resident's going through the door. 11. Record review and interview with the Administrator, on 11/01/13 at 8:30 AM, revealed a Quality Assurance (QA) meeting included the Medical Director, DON, Unit Managers, Director of Clinical Services, and Administrator on 10/21/13. She stated audits were developed and directives were given to ensure removal of Immediate Jeopardy. Review of the Elopement at Risk binders on 10/22-24/13 and 10/30-11/01/13, revealed they had been reviewed and updated with resident census and appointments. No additional residents had been identified at risk for elopement. Review of the facility's audit forms and interview with the DON, on 11/01/13 at 11:50 AM, revealed audits were developed for nursing to ensure walking rounds were done; audits to verify the function and placement of WanderGuards; resident elopement assessments; and care plan audits would be completed by the Nurse Managers and/or DON and given to the DON weekly. She stated she would review all information and report to the Administrator and QA. Interview with the Administrator, on 11/01/13 at 8:30 AM, revealed she would be auditing the Security Guards three (3) times a week to ensure competency and knowledge of the door alarm and locking requirements, and use of the Elopement Risk binder. She stated the Maintenance Director would continue to complete audits on the exit doors to ensure they were functioning appropriately.	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

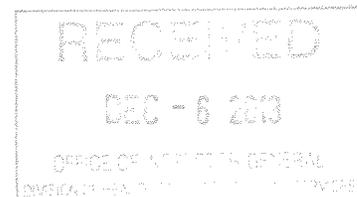
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 19 12. Record review and interview with the DON on 10/31/13 at 11:50 AM, revealed she had in-serviced all nurses regarding the use of the computer monitor and to not touch or change the volume of the monitor system, on 10/24/13. She stated the computer's on/off button was covered by the Executive Director to prevent the staff from turning it off. Interview with LPN #7, on 10/31/13 at 12:54 PM, and RN #3 at 1:12 PM, revealed they had been in-serviced on the purpose and use of the computer monitor and they were not allowed to adjust the volume or turn the monitor off. They said the alarm system on the doors was in place to keep residents safe and nurses had to verify the placement of the resident's WanderGuard and check the function of the WanderGuard weekly. 13. Record review and interview with the DON, on 10/31/13 at 1:18 AM, revealed she had in-serviced the Nurse Managers on the use and purpose of the audits developed to ensure on-going compliance with the facility policy's for: residents' elopement risks assessments; updating; and reviewing the Elopement binder. She stated she would gather all audits from the Unit Nurse Managers to review and submit to the Administrator. She stated the results of the information would be presented at the monthly QA meetings. 14. Record review of all in-service training content and staff sign-in sheets and interview with LPN #1, on 10/22/13 at 3:57 PM, LPN #2, on 10/22/13 at 3:25 PM, and RN #1 on 11/01/13 at 11:20 AM, revealed they were in-serviced on the revised care plan policy and assisted with the in-servicing of all the nurses. They were to	F 280			



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

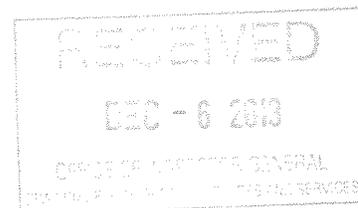
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 20 review all new physician orders in the daily meeting and then audit the care plans for revisions. They stated the audits would go to the DON and QA.	F 280	1. At 7:30 am on 10/20/13, LPN #2 directed all staff on duty to conduct a facility wide search of resident #1 and took a census to ensure that all other residents were accounted for. Upon determining that resident #1 was not in the center, on 10/20/13, a licensed nurse notified the NHA, DON, police, physician, and Resident #1's responsible party. On 10/20/13, the DON and a licensed nurse completed a full body assessment on Resident #1 upon his return to the facility with a CNA # 4 at 8:29am. On 10/20/13, the DON checked Resident #1's wander guard for placement and functionality and the wander guard device worked appropriately. On 10/20/13, the Maintenance Director checked all exit doors for functionality and they were all noted to be operating appropriately.	
F 323 SS=J	15. Interview with the Administrator, on 11/01/13 at 1:30 PM, revealed she did have a job performance review with the Executive Director on 10/24/13 of the job responsibilities, duties and roles along with the company's Quality Assessment and Assurance policy to assure ongoing knowledge and performance of duties and responsibilities. 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 interview, record review and review of the facility's policy, investigation, observation Flow Sheet, video surveillance, and WanderGuard Activities Report, it was determined the facility failed to have an effective system to ensure the provision of adequate supervision to prevent accidents for one (1) of eight (8) sampled residents, Resident #1. The facility failed to supervise residents at risk for elopement, failed to ensure the security guard's competency of the security system, failed to	F 323	On 10/20/13, the DON directed a licensed nurse to notify resident #1's responsible party and physician of his condition and safe return to the center. On 10/20/13, Resident #1's physician and/or ARNP ordered lab work. On 10/20/13, a licensed nurse reported the results of the lab work to the physician and/or ARNP and the results were noted unremarkable. On 10/21/13, Resident #1's physician completed an assessment of his condition and noted that Resident #1 was overall stable.	



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

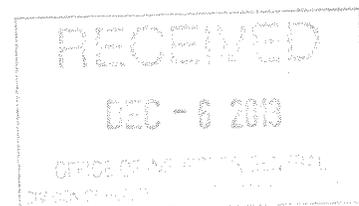
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 21</p> <p>ensure the security system monitor was functioning at all times, and failed to ensure staff conducted safety rounds.</p> <p>On 10/20/13 at 5:37:21 (from the WanderGuard report) Resident #1 exited the facility without staff knowledge when the security guard entered an over ride code to open the front entrance door and allowed the resident to leave the facility. Resident #1 was found by a staff member ambulating on a sidewalk in front of a fast food restaurant 0.3 miles from the facility in a heavy traffic, four (4) lane street and was returned to the facility unharmed at approximately 8:29 AM on 10/20/13, approximately two (2) hours and fifty-two (52) minutes after he/she left the facility. Review of the National Weather Service archive temperature log revealed the temperature on 10/20/13 was 39 degrees Fahrenheit. Resident #1 was assessed by the facility as having no injuries.</p> <p>The facility's failure to have an effective system to ensure the provision of adequate supervision for residents assessed at risk for elopement placed residents in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 10/24/13 and determined to exist on 10/20/13. The facility was notified on 10/24/13 of the Immediate Jeopardy and Substandard Quality of Care.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 10/30/13 which alleged the Immediate Jeopardy was removed on 10/25/13. The State Survey Agency validated the removal of Immediate Jeopardy on 10/25/13 as alleged, prior to exit on 11/01/13. The scope and severity was lowered to a "D" while the facility develops</p>	F 323	<p>On 10/20/13, the NHA and DON conducted a preliminary family meeting with resident #1's family members to inform the family of what the NHA and DON knew at present. On 10/20/13, the NHA and DON also scheduled a follow-up family meeting to be held on October 21, 2013 at 1:00PM to present more information.</p> <p>On 10/20/13, the DON reviewed resident #1's elopement assessment dated 10/20/13. The DON also spoke with direct care givers to determine alternative interventions for Resident #1. Resident #1's exit seeking care plan was revised by a licensed nurse with new interventions on 10/20/13 following his return to the building that included increased supervision of 1:1 supervision for 24 hours. At 7:15PM on October 20, 2013, the NHA and DON assigned a licensed nurse to complete a check on resident #1 and his CNA sitter every 15 minutes for the next 24 hours. Resident #1's information sheet was audited by the Director of Clinical Support Services (DCSS) and found to be correct in the At Risk for Elopement binder at security, reception, and nursing station on 10/20/13.</p>		



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

PRINTED: 12/03/2013
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 11/01/2013
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 22 and implements a Plan of Correction and the facility's Quality Assurance program monitors the effectiveness of systemic changes to achieve and maintain substantial compliance. The findings include: Review of the facility's policy regarding Procedure for Door Alarm/Lock Policy (not dated) revealed all staff had the responsibility to assure that residents who wander would not leave the building unescorted. Staff was directed to respond when a door alarm sounds. The WanderGuard computer located at the nurse's station were not to be touched unless authorized. All staff that was in close proximity was responsible for going to the WanderGuard computer when an alarm sounds to alert others as to which door was alarming. Staff was directed that at no time were authorized personnel allowed to place a door alarm on bypass/silence. Unit Managers, DON, Maintenance and Administrator were the only ones authorized. Review of the facility's Elopement Policy (not dated) revealed the residents at risk for elopement or unsafe wandering would be identified through assessment. The facility would enhance staff awareness of residents at risk and educate them in approaches and interventions for those residents. Interview with the Administrator revealed the facility did not identify the required safety rounds of residents as a policy, but it was the facility's standard of practice for Certified Nursing Assistants and Nurses to perform walking safety rounds at the beginning and end of the shift to assure resident safety.	F 323	On October 21, the NHA and DON directed the assigned, licensed nurse to check on resident #1 every 30 minutes for 24 hours. On 10/24/13, Resident #1's exit seeking care plan was reviewed and revised by the DON to include every two hour safety checks. Resident #1's comprehensive care plan was reviewed by a licensed nurse on 10/24/13 to ensure the care plans included all information contained on the C.N.A. Care plans. Resident #1's family was consulted on 10/25/13 by the DON to gather any further insight into appropriate interventions. On 10/25/13, Resident #1's family did not give the DON any further insight into appropriate interventions.		



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

PRINTED: 12/03/2013
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 11/01/2013
--	--	--	---

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
--------------------	--	---------------	---	----------------------

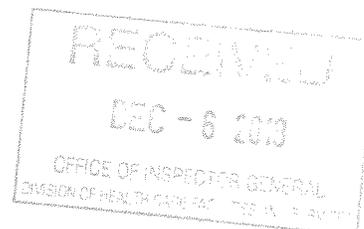
F 323 Continued From page 23
Review of the clinical record revealed Resident #1 had been assessed by the facility to be at risk for elopement and had a WanderGuard bracelet on his/her right wrist. On 10/20/13 at approximately 7:30 AM, Resident #1 was discovered missing from the facility during the morning tray pass. Resident #1 was found by a staff member ambulating on a sidewalk in front of a fast food restaurant 0.3 miles from the facility in a heavy traffic four (4) lane street and was returned to the facility unharmed at approximately 8:29 AM on 10/20/13. Review of the National Weather Service archive temperature log revealed the temperature on 10/20/13 was 39 degrees Fahrenheit.

Review of the facility's investigation, dated 10/20/13, revealed upon return to the facility Resident #1 was wearing a WanderGuard, which alarmed as he/she entered the facility. The investigation revealed all exit doors and WanderGuard system had been checked to ensure they were operating properly. During the process of gathering statements, the facility received a return call from the security guard who was on duty from 11:00 PM - 7:00 AM. During the interview he informed the Director of Clinical Services and the Administrator that he had let someone out of the facility that appeared to be a visitor. Review of the facility's investigation also revealed print-out logs of documentation for the date/time/location of exit doors and WanderGuard bracelet numbers that indicated if a resident with a WanderGuard bracelet had exited an alarmed door, or if a resident with a WanderGuard bracelet had been near an alarmed exit door.

Review of WanderGuard Activities Report for

F 323 2. All 78 resident's elopement assessments were reviewed or reassessed by the DON, Unit Managers, Director of Clinical Support Services (DCSS), and the MDS Coordinator on 10/20/13. During the review on 10/20/13, the same 5 previously identified residents (Resident #1, #5, #6, #7, and #8) were assessed by a licensed nurse to be at risk for elopement. The DON checked and tested all resident wander guard devices for Resident #1, #5, #6, #7, and #8 for functionality and placement; which revealed that they worked appropriately on 10/20/13. On 10/20/13, the Maintenance Director checked all exit doors for functionality and they were all noted to be operating appropriately.

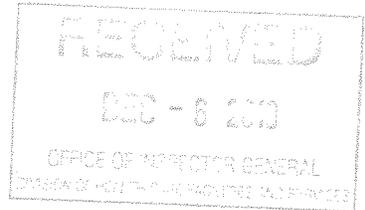
Resident #1, #5, #6, #7, and #8 also had their exit seeking care plans reviewed and revised as needed based on the most current elopement assessment by the Director of Nursing on 10/20/13 and again on 10/24/13. Resident #1, #5, #6, #7, and #8 care plans all include supervision by nursing staff. All residents assessed to be at risk for elopement are monitored Q2 hours. Resident #1, #5, #6, #7, and #8 comprehensive care plans were reviewed by a licensed nurse on 10/24/13 to ensure the care plans included all information contained on the C.N.A. Care plans and were accurate as to care provided.



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

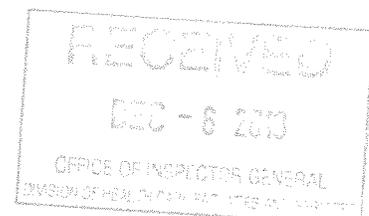
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 24 10/20/13 indicated Resident #1 was near the Main Street 2 Exit at 5:36:49 and 5:37:09 and caused the door to alarm at 5:37:21 AM and 5:37:35 AM. Resident #1's WanderGuard did not indicate activity on the system again until 8:29:31 AM at the Main Street 2 Exit when the resident returned to the facility. Review of the facility's video-surveillance tape for 10/20/13 at 5:37:35 AM, revealed Resident #1 was observed to walk through opened doors and go down the facility's main hallway towards the facility's front door. The resident wore a short sleeve T-shirt, jeans, ballcap, and shoes. The resident walked to the entrance door and pushed on the door, turned away and began to walk back towards the unit. Resident #1 was observed to turn his/her neck to the left, a man identified as Security Guard #6 walked to the door and was observed to push buttons on the key pad, he pushed the buttons again releasing the lock, opening the facility's front door and allowed Resident #1 to exit the building. Telephone interview with Security Guard #6, on 10/23/13 at 10:51 AM, revealed he had seen the resident on the nursing unit sitting on a couch about 11:30 PM the evening of 10/19/13, and again around 1:00 AM on 10/20/13. He stated he thought it was about 2:00 to 3:00 AM, when he saw the resident again. He stated the resident punched the door to get out. He said he asked Resident #1 if he/she wanted to go out and the resident shook his/her head yes, but the resident never said anything to him. He stated the alarm sounded and he had to enter the code again to release the lock and let the resident leave the facility. Per interview, he was supposed to look at the Security Communication book and check it	F 323	3. On 10/20/13, the NHA reviewed The Door Alarm/Lock Policy, Smoking Policy, Missing Resident, and Elopement and Fall Risk policies and procedures. On 10/20/13 and 10/21/13, the DCSS and Unit Manager in-serviced all facility staff with the exception of as needed staff and those on illness/LOA on Door Alarm/Lock Policy, Smoking Policy, Missing Resident, and Elopement and Fall Risk Policies. The Fall policy addresses supervision of the resident. As of 11/26/13, all remaining facility staff has been educated by the NHA, DON, Unit Manager, and/or licensed nurse on the Door Alarm/Lock Policy, Smoking Policy, Missing Resident, and Elopement and Fall Risk Policies. On 10/20/13, the NHA notified Frederick's Security of the incident regarding Resident #1. At that time, the NHA informed Frederick Security that the Security Guard #6 is no longer able to work for any Christian Care Communities campus.	



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

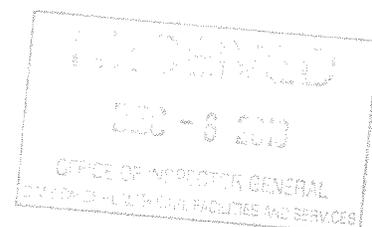
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 25 every so often for pictures and demographic data on elopement risks, appointments and who would transport the resident, and current census; however, he had not reviewed the book for 4-5 weeks. He revealed he did not recognize the person as a resident because the resident had on regular clothes, a blue outfit, pants, shoes, shirt and the resident looked like he/she was waiting for somebody. He did not notify the nursing staff of the resident leaving the building, and he did not verify if the resident was a visitor by comparing the sign in/out sheet as he was trained. He stated he accepted the responsibility, that he let Resident #1 exit the building unsupervised. Review of the clinical record for Resident #1 revealed the facility initially admitted the resident on 11/29/12 and the facility assessed the resident as having a cognition score of four (4) on the Minimum Data Set (MDS) indicating a moderate impairment of cognition. Review of the physician orders, dated 10/01/13 to 10/31/13, and the face sheet revealed diagnoses of Senile Dementia, and Other Organic Psychotic Conditions. Review of the Risk of Elopement/Wandering Review, dated 01/28/13, revealed the facility assessed Resident #1 for elopement due to the resident verbalizing the expressed desire to go home, wandering aimlessly in the facility, and the family/responsible party voiced concerns that would indicate the resident may have wandering tendencies or try to leave. Review of the Comprehensive Care Plan initiated on 01/28/13 to address the problem of Resident #1 as at risk for elopement revealed a goal the resident would not exit the center unattended. The approach was for the resident to use a WanderGuard bracelet, a picture was to be displayed in the	F 323	On 10/20/13, all Security staff working in the building was in-serviced by the DCSS on the Door Alarm/Lock Policy, Smoking Policy, Missing Resident, and Elopement and Fall Risk Policies. To ensure that the security guards are trained properly, as of 10/21/13, the NHA tests all security guard knowledge of the door alarm/lock policy by having them complete a post-test prior to working and pass at 100% in order to continue working for the center. The Administrator or DON will audit all security staff three times weekly x 12 months on knowledge of Door Alarm/Lock Policy and the security At Risk for Elopement binder. The Security binder contains resident census, scheduled appointments, pending discharges, pending admissions and residents at risk for elopement.		



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

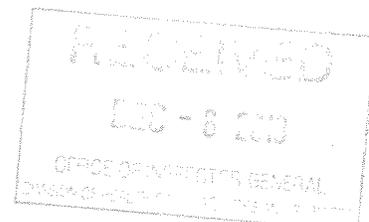
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 26 Elopement Book, and staff was to observe potential exit seeking activity. Staff was to approach the resident in a calm manner, redirect the resident to another location, walk with the resident in the direction he/she was going and assume leadership of direction back to area of greater safety. Additional approach was to check placement of the WanderGuard every shift and the function every week. Resident #1 was reassessed on 04/01/13, 06/10/13, and 09/10/13 for his/her risk of elopement/wandering behavior. The facility identified the resident as a continued elopement risk due to expressions to leave facility unattended and walking towards exit doors. There was no direction to staff as to the frequency of monitoring Resident #1. Telephone interview with Certified Nursing Assistant (CNA) #1, on 10/22/13 at 2:01 PM, revealed she was assigned to Resident #1 from 6:45 PM on 10/19/13 to 7:00 AM on 10/20/13. CNA #1 indicated the staff had to check the residents every two (2) hours and she had seen the resident at 12:00 AM in the rotunda (an area adjacent to the nurses' station with two recliners and a small couch). She took the resident to his/her room to ensure he/she was clean and dry, and then the resident went to bed in his/her clothes. However, she did not check on the resident again until approximately 5:30 AM when she changed him/her, and the resident walked out of the bedroom as if he/she was going to the rotunda. Further interview revealed during the change of shifts, she and the on-coming staff was to do a physical walk around and report what was going on with each resident they were assigned. However, CNA #2 did not want to do a walk through the morning of 10/20/13 at approximately 6:45 AM. CNA #1 further revealed the resident	F 323	On 12/5/13, the Administrator developed a policy and procedure which details the responsibilities of the security guards and their role in keeping our residents safe. It also contains information on the expectation that all security guards must check the elopement at risk binder daily at the beginning of their shifts and as needed to keep our residents safe. In addition, it details the expectation that the security guard must communicate with a licensed nurse to ensure that the resident is signed out at the nurse's station and a licensed nurse is aware that they are leaving the center before allowing them to exit the center. A copy of the policy and procedure is attached for your review. (Exhibit One). Several members of the QA Committee (DON, Sen. Executive Director, Administrator, Unit Manager, and HR Director) reviewed the Security Policy on 12/5/13 to give feedback on the policy and to suggest additions/changes to the policy before implementing it. On 12/5/13, the above noted members of the QA committee agreed to implement the policy.		



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

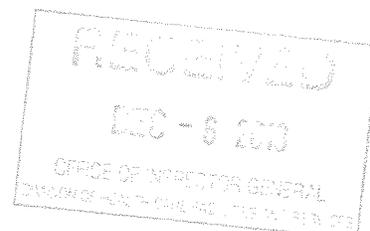
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 27</p> <p>had a WanderGuard on and any resident with a WanderGuard on who tried to open an exit door would cause the door to lock and alarm, and someone would have to physically put in a code. She stated she did not hear any alarms sounding the morning of 10/20/13.</p> <p>Telephone interview with LPN (Licensed Practical Nurse) #1, on 10/22/12 at 4:04 PM, revealed she had last seen Resident #1 during the end of her medication pass about 5:38 AM on 10/20/13. She had turned the light on at the desk and was charting when she saw Resident #1 walking up the hallway toward the nursing station. Per interview, it was not unusual to see Resident #1 ambulating in the rotunda and he/she would sit down. She stated the resident had a WanderGuard on and when staff was at the desk they could hear the alarms loud and clear. LPN #1 indicated it was her understanding the exit doors would alarm if a resident with a WanderGuard bracelet got near an exit door, and it was also her understanding the WanderGuard alarms on the exit doors would help the staff keep the residents safe. However, she did not hear an alarm sound the morning of 10/20/13. LPN #1 further stated she did not do a walking round with on-coming nurse LPN #2, on 10/20/13; LPN #2 declined to do a walk around because she was not feeling well. When LPN #1 left the facility at 6:40 AM, LPN #1 was not aware Resident #1 had left the building.</p> <p>Telephone interview with LPN #2, on 10/22/13 at 3:25 PM, revealed she was the first shift nurse for Resident #1, the morning he/she had left the building. Per interview, nurses sometimes did a walking round with the off-going or on-coming staff; however, the morning the resident had left</p>	F 323	<p>To ensure that all security guards understand the Security Policy and Procedure - Residents, as of 12/5/13, all security guards are required to take a post-test to ensure their Competency and understanding. The Administrator provided a copy of the policy to Frederick Security on 12/5/13 to ensure that all security guards working at our location are trained on this policy. Brian Frederick owner of Frederick Security is the supervisor of all security guards. Brian will ensure that Ben Shaw, his second in command and other Lead Security guards that check on center security guards daily during their shift to ensure that they are on post and do not have questions or concerns are educated on the policy and submit a statement to the Administrator to ensure that this is complete by 12/7/13. The Administrator or DON will also train the security guard scheduled to work at the center on 12/5/13 on the new policy and procedure and will also administer a post-test to ensure competency and understanding. All subsequent security guards scheduled to work at the center will be trained by the Administrator and/or DON before being allowed to work at the center. The DON and/or Unit Manager will educate all Nursing staff to notify the security guard of a wandering resident by 12/7/13.</p>		



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

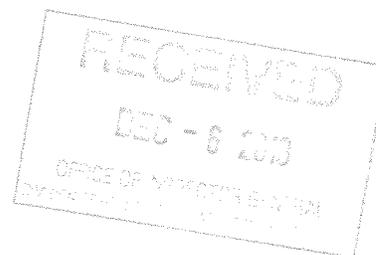
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 28</p> <p>the building they did not do a walking round and she only received a verbal report from LPN #1. CNA #2 had notified her that she was unable to locate Resident #1; a search was initiated; and, she called RN #1 to report the missing resident. LPN #2 stated she had not heard any alarms that morning.</p> <p>Telephone interview with CNA #2, on 10/23/13 at 10:42 AM, revealed she was in the facility on 10/20/13 at 6:45 AM. She stated she was supposed to do a walk through with the off-going CNA and receive a report on each resident and visually see the residents. However, she did not do a walk through on 10/20/13 and CNA #1 had reported that everyone was fine. Further interview revealed it was not normal practice to see the residents on a walk through, but they were supposed to. In addition, they were to round every two (2) hours on the residents. Per interview, CNA #2 went to get Resident #1 up, about 7:30 AM, and the resident was not in his/her bed. The resident's bed was made, and she assumed Resident #1 was up front in a chair. The CNA indicated the resident was not there and she began to look around and then told the nurses and other CNAs. She stated a search to find Resident #1 began and the resident was found right away. The resident had a WanderGuard on his/her wrist. CNA #1 revealed the resident was confused; however, he/she was easily redirected. She stated the resident would have been identified as missing earlier if they had done the safety rounds as required.</p> <p>Telephone interview with CNA #4, on 10/24/13 at 8:30 AM, revealed he found Resident #1 walking in front of a nearby fast food restaurant. He stated the resident and he walked to the pawn</p>	F 323	<p>Beginning 12/5/13, The Administrator or DON will audit all security guards 3 x weekly x 12 months on the Security Policy and Procedure – Residents; which details the requirements of their role and responsibilities in keeping our residents safe and from exiting the center unsupervised and without a licensed nurse's knowledge by administering a post-test to test the security guard's continued competency.</p> <p>CNA #1, CNA #2 and LPN #1 and LPN#2 respectively all had responsibility for caring for the resident during third shift on October 19, 2013 and first shift on October 20, 2013. On 10/20/13, the NHA and DON issued a corrective action to CNA #1, CNA #2 and LPN #1 and LPN#2 for not completing their safety rounds during their change of shift.</p> <p>On 10/21/13, the NHA and DON directed all nursing staff that safety rounds must be conducted for all shift changes. On 10/21/13, the DON also re-educated all nursing staff on center procedures that direct a check of each resident every 2 hours at minimum. To ensure this standard of walking rounds at shift change is met, as of 10/21/13, the nursing staff must provide the DON a mutually-signed copy of the nursing staff member's care records for their shift daily.</p>		



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

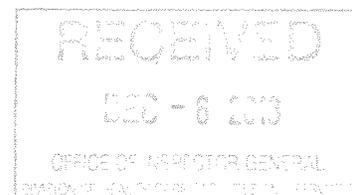
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 29</p> <p>shop and he called for staff to pick them up. The resident was cold and he placed his jacket on the resident. He revealed the resident had a short sleeve T-shirt and blue jeans on, with a ball cap, shoes and socks. When they returned to the facility, staff put a blanket around the resident, escorted the resident to his/her bedroom, where the nursing staff assessed the resident.</p> <p>Further interview with LPN #2 revealed Resident #1 was confused, and the resident reported he/she was cold when returned to the facility. She assessed the resident upon return with no injuries. Review of the National Weather Service archive temperature log revealed the temperature on 10/20/13 was 39 degrees Fahrenheit.</p> <p>Further review of the video-surveillance tape revealed on 10/19/13 at approximately 7:42 PM, a nurse (identified by facility staff as LPN #8) was observed in the nurses station and as she walked by the computer monitor she turned it off. The monitor was observed on the video-surveillance tape to be off until a nurse (identified by facility staff as LPN #3) observed the monitor and turned it on at approximately 7:51 AM on 10/20/13.</p> <p>Interview with LPN #8 on 10/25/13 at 8:33 AM revealed on 10/19/13 at approximately 7:42 PM she reset the monitor at the nurses station because an alarm had sounded. She pushed the button on the monitor twice and did not realize the monitor had not come back on. She revealed it was her mistake not to stay by the monitor until it rebooted. Due to the monitor being turned off, the alarm system did not sound at the nurses station on 10/20/13 at 5:36:49 AM, 5:37:09 AM, 5:37:21 AM and 5:37:35 AM per the facility's WanderGuard Activities Report. Per interview,</p>	F 323	<p>On 10/21/13, LPN #8 received corrective action up to and including termination for turning the security system monitor off on 10/19/13. LPN #8 is no longer employed at the center. On 10/23/13, the DON conducted an education session for all licensed nurses; providing directions that the wander guard computer monitor's volume level may not be adjusted for any reason. On 10/23/13, the DON also provided instruction that the monitor must not be turned off. To ensure that the monitor volume level remained as directed by the NHA and DON, the ability to change the monitor volume was disabled on October 24, 2013 by the Senior Executive Director. On 10/24/13, the Senior Executive Director also disabled the ability to turn the monitor on and off.</p> <p>4. All at Risk for Elopement Binders located at the reception, security and nurse's station will be audited one time weekly x 12 months for accuracy by the DON and/or Unit Managers.</p> <p>Documentation of placement and function of the Wander guards will be audited one time weekly x 12 months by the DON and/Unit Managers. This audit will include visualization of the licensed nurse checking placement and function of the wander guard bracelet.</p>		



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

PRINTED: 12/03/2013
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 11/01/2013
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 30</p> <p>LPN #1 and CNA #1 stated they did not hear alarms sound the morning of 10/20/13, and interview with LPN #1 and LPN #2 revealed they did not notice the monitor was turned off.</p> <p>Interview with the Maintenance Supervisor on 10/23/13 at 3:06 PM, revealed he was called to the facility on 10/20/13 after Resident #1's elopement from the facility. He stated he checked the doors five days a week. He stated there were no problems and they were working correctly prior to the weekend and on 10/20/13. He stated the nurses checked the transmitters daily to ensure they were working appropriately. He stated the overhead alarm sounds through the computer monitor and it would have alerted staff of the resident exiting the building. If staff entered a reset code the system would not have alarmed overhead. He stated if the computer was turned off, the transmitter and everything would work appropriately. Additionally, he stated the alarm system sounds at the computer/monitor terminal at the nurses' station, and if it were turned off staff would not be alerted if a resident was to exit the building.</p> <p>Interview with the Director of Nursing (DON), on 10/25/13 at 10:29 AM, revealed she was notified about 7:50 AM on Sunday morning (10/20/13) by LPN #2 of Resident #1 being missing. She arrived to the facility about 8:15 AM and directed staff to notify the police and family and she called the Administrator and left to search the area for the resident. She stated she received a call from LPN #3 who reported the resident had been found. She and LPN #2 assessed Resident #1 upon his/her return to the facility and the resident was found with no injury; however, the resident reported being "cold". Further interview revealed</p>	F 323	<p>Ten percent of residents' Elopement assessments will be audited weekly x 12 months by the DON and/or Unit Managers. If resident is found to be at risk, the corresponding care plan will be reviewed and revised by the DON, Unit Manager and/or licensed nurse if needed.</p> <p>The Administrator or DON will audit all security staff three times weekly x 12 months on knowledge of Door Alarm/Lock Policy and the security At Risk for Elopement binder. The Security binder contains resident census, scheduled appointments, pending discharges, pending admissions and residents at risk for elopement.</p> <p>On 12/5/13, the Administrator developed a policy and procedure which details the responsibilities of the security guards and their role in keeping our residents safe. It also contains information on the expectation that all security guards must check the elopement at risk binder daily at the beginning of their shifts and as needed to keep our residents safe. In addition, it details the expectation that the security guard must communicate with a licensed nurse to ensure that the resident is signed out at the nurse's station and a licensed nurse is aware that they are leaving the center before allowing them to exit the</p>		



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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

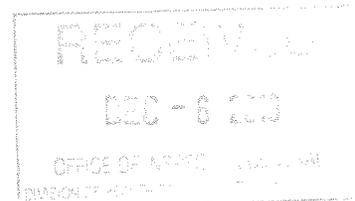
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/01/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, 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 31 she had viewed the monitor and had seen some alerts were still blinking where staff had not addressed them. She stated after the alarms sounded the nurse had to walk to the monitor to reset it. She stated staff was taught how to read the monitor to identify when someone was at the door and how to reset it. She stated the door alarm system had worked appropriately; however, the monitor had been turned off and staff could not hear the alarms sounding. She stated staff was to sign off on the CNA assignment sheets to verify they had visually seen the resident. Per interview, she did not think she had to monitor the nurses to ensure they did their rounds; however, staff could have found the resident earlier if they had completed the walking safety rounds and identified him/her as missing. She revealed she did not know how the resident exited until they reviewed the video-surveillance tape and discovered the Security Guard had let the resident out of the building. Interview with the Administrator, on 10/22/13 at 8:15 AM, revealed review of the video surveillance tape revealed the Security Guard had entered the reset code which allowed Resident #1, who was wearing a WanderGuard to exit the building, without sounding the alarm. She stated the Security Guard thought the resident was a visitor and failed to contact the nurse or review the elopement binder, prior to letting the resident exit the building. She stated during the time the monitor was disabled staff would not have heard any alarms to notify them of a resident wearing a WanderGuard trying to exit the facility. The Administrator stated the purpose of the WanderGuard alarm system on the exit doors and the contracted Security Guards was to assist in keeping the residents safe. In addition,	F 323	center. A copy of the policy and procedure is attached for your review. (Exhibit One). Several members of the QA Committee (DON, Sen. Executive Director, Administrator, Unit Manager, and HR Director) reviewed the Security Policy on 12/5/13 to give feedback on the policy and to suggest additions/changes to the policy before implementing it. On 12/5/13, the above noted members of the QA committee agreed to implement the policy. To ensure that all security guards understand the Security Policy and Procedure - Residents, as of 12/5/13, all security guards are required to take a post-test to ensure their Competency and understanding. The Administrator provided a copy of the policy to Frederick Security on 12/5/13 to ensure that all security guards working at our location are trained on this policy. Brian Frederick owner of Frederick Security is the supervisor of all security guards. Brian will ensure that Ben Shaw, his second in command and other Lead Security guards that check on our center security guards daily during their shift to ensure that they are on post and do not have questions or concerns are educated on the policy and submit a statement to the Administrator to ensure that this is complete by 12/7/13.		



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

PRINTED: 12/03/2013
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 11/01/2013
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 32</p> <p>she stated staff was to complete walking rounds and visualize each resident during shift change. She stated the staff's failure to do safety rounds at shift change to visualize each resident caused a delay in initiating a search for the resident. She further stated it was ultimately her responsibility to ensure the contracted providers, such as the Security Guards, were informed of the facility policies and procedures and trained regarding residents at risk for elopement.</p> <p>Review of the acceptable AOC revealed the facility took the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. A facility wide search and resident census was taken by the charge nurse immediately on 10/20/13 at 7:30 AM, to determine if Resident #1 was missing and all other residents were present. The Administrator, DON, police, physician and family of Resident #1 were all notified by telephone. 2. After Resident #1's return to the facility at 8:29:31 AM by CNA #4, the DON and LPN #2 assessed the resident. They assigned a LPN to complete a check on the resident and CNA sitter every fifteen (15) minutes for twenty-four (24) hours. On 10/21/13 the Administrator and the Director of Nursing (DON) directed the assigned staff to check on the resident every thirty (30) minutes for twenty-four (24) hours. 3. An investigation was initiated by the DON and the Administrator, on 10/20/13 at approximately 8:45 AM with interviews of staff on duty and telephone interviews with staff from the previous shift, and review of the video-surveillance tape. All exit doors were checked for functionality by 	F 323	<p>The Administrator or DON will also train the guard scheduled to work at the center on 12/5/13 on the new policy and procedure and will also administer a post-test to ensure competency and understanding. All subsequent security guards scheduled to work at the center will be trained by the Administrator and/or DON before being allowed to work at the center. The DON and/or Unit Manager will educate all Nursing staff to notify the security guard of a wandering resident by 12/7/13.</p> <p>Beginning 12/5/13, The Administrator or DON will audit all security guards 3 x weekly x 12 months on the Security Policy and Procedure - Residents which details the requirements of their role and responsibilities in keeping our residents safe and from exiting the center unsupervised and without a licensed nurse's knowledge by administering a post-test to test the security guard's continued competency.</p> <p>The Maintenance Director will continue to check exit doors for functionality a minimum of 4 times weekly.</p> <p>All of the above listed audits and checks will be submitted to the Administrator and reported to the QA Committee monthly x 12 for further review and recommendations. The Senior Executive</p>		



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

PRINTED: 12/03/2013
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 11/01/2013
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 33</p> <p>the Maintenance Supervisor on 10/20/13 and all exit doors alarming appropriately. The DON notified the physician and assessed the resident along with LPN #2.</p> <p>4. On 10/20/13, after review of the surveillance video revealed the Security Guard #6, had entered the bypass code and allowed Resident #1 to exit the building, unsupervised. The Administrator contacted the Security Agency to obtain contact information for Security Guard #6. The facility notified the Security Agency on 10/20/13 that effective immediately Security Guard #6 was no longer authorized to work at the facility.</p> <p>5. On 10/20/13, after Resident #1's elopement from the facility, the Administrator determined the Security Communication binder and Elopement at Risk binder were in place and up-to-date as of 10/20/13 with all identifying information and a current photo in the binder for the five (5) residents (to include Resident #1) who had been assessed as being at risk for elopement. On 10/20/13 the DON checked the five (5) residents who had been assessed as being at risk for elopement with WanderGuard bracelets to ensure the bracelets' placement and functionality. The Administrator and the DON had identified the same five (5) at risk residents of the seventy-eight (78) residents assessed. The Director of Clinical Services, the DON, and RN #1 reassessed all seventy-eight (78) residents for their elopement risks on 10/20-21/13.</p> <p>6. The Administrator and the Director of Clinical Services determined which security guards were scheduled to work from 10/20/13 and subsequent shifts and re-educated them on the policies</p>	F 323	<p>Director will review the QA minutes monthly and attend a QA meeting on a quarterly basis to monitor compliance.</p> <p>5. All corrective measures will be completed by 12/8/13.</p>		

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

PRINTED: 12/03/2013
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 11/01/2013
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 34</p> <p>related to elopement and completed a competency quiz with a score of 100% before allowing them to work any further shifts. The competency quiz was administered to all two (2) security guards scheduled to work by the Director of Clinical Services on 10/21/13.</p> <p>7. A minimum of every two hour facility safety rounds were continued by the staff to ensure resident safety. Corrective action was issued to all nursing staff members with responsibility for caring for the resident during third shift on 10/19/13 and first shift 10/20/13; up to and including termination of employment. On 10/21/13 directives by the Administrator and DON and the QA Committee for all nursing staff that safety rounds must be conducted for all shift changes. To ensure this standard of walking rounds at shift change is met the nursing staff must provide the DON a mutually-signed copy of the staff member's care records for their shift.</p> <p>8. All seventy-eight (78) resident's elopement assessments were reviewed or reassessed by the DON, Unit Managers, and the Director of Clinical Services, and reviewed on 10/20/13 the elopement assessments and care plans of the five (5) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct. In addition, all residents' admission assessments, care plans, CNA care records, assignment sheets, elopement, fall and smoking at risk assessments beginning on 10/20/13 and completed on 10/24/13 with revisions as indicated.</p> <p>9. On 10/20/13 and 10/21/13, all current staff (with the exception of as-needed staff or those on</p>	F 323			

