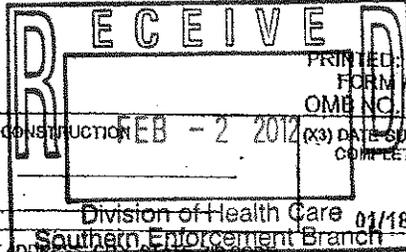


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/18/2012
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	<u>Disclaimer for Plan of Correction</u>	
F 282 SS=D	<p>A standard health survey was conducted on 01/16-18/12. Deficient practice was identified at 'D' level.</p> <p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure services were provided to one of nineteen sampled residents (Resident #4) in accordance with the resident's plan of care. Documentation revealed the facility had developed a plan of care with interventions for Resident #4 that included fall mats to each side of the resident's bed. However, observations revealed fall mats had not been placed on each side of Resident #4's bed as planned in the comprehensive plan of care.</p> <p>The findings include: A review of the facility's policy titled "Care Plans" (revised date of November 2008) revealed the Care Plan should reflect the following: Interventions, the specific and realistic action or interventions that staff takes to assist the resident in meeting/achieving goals. A review of the medical record for Resident #4</p>	F 282	<p>Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Lancaster of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Lancaster files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE ADMINISTRATOR	(X6) DATE 02/02/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(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 282	<p>Continued From page 1</p> <p>revealed the facility admitted the resident on 03/29/11, with diagnoses that included Alzheimer's, Difficulty Walking, and Debility.</p> <p>A review of an Annual Minimum Data Set (MDS) assessment dated 04/05/11; revealed the facility had assessed Resident #4's cognition to be severely impaired. The MDS also revealed, based on the assessment, that the resident required extensive assistance of two persons for transfers.</p> <p>A review of the comprehensive care plan dated April 2011 for Resident #4 revealed facility staff had assessed Resident #4 to be at risk for falls. Based on the care plan, fall mats were to be placed on each side of Resident #4's bed daily.</p> <p>A review of documentation of the Certified Nurse Aide Sheet dated January 2012, used as a daily reference of the resident's care needs, revealed the aides were to ensure fall mats were to be placed at each side of Resident #4's bed daily.</p> <p>Observations conducted on 01/16/12, at 10:45 AM, 12:30 PM, 2:50 PM, and 4:00 PM, and on 01/17/12, at 10:00 AM, 12:45 PM, and 2:45 PM, revealed fall mats had not been placed on each side of Resident #4's bed as planned in the comprehensive plan of care or on the Certified Nurse Aide Sheet.</p> <p>An interview conducted with CNA #1 on 01/17/12, at 4:45 PM, revealed Resident #4 was to have fall mats on each side of the bed. However, although the CNA could not remember the name of the nurse, the CNA stated he/she had been told by a nurse not to put the fall mats on the floor because</p>	F 282	<p>F 282</p> <p>Christian Care Center of Lancaster believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Residents</u></p> <p>Safety devices for Resident #4 were reviewed by the Director of Nursing, Assistant Director of Nursing, MDS RN, and MDS LPN on 1/18/12. A bolster mattress was currently in place and effective for reducing falls for Resident #4. As a result of the review, the floor mats were discontinued for Resident #4 on 1/18/12. Care plans and CNA flow sheet for Resident #4 were updated on 1/18/12.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>An audit of all safety devices was conducted by charge nurses on 1/17/12, which verified that care planned interventions and CNA flow sheet matched what was currently in place for each resident with a safety device. The audit was reviewed by the Director of</p>		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(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 282	<p>Continued From page 2</p> <p>the resident no longer needed them. The CNA confirmed that documentation on the CNA's resident care sheet indicated fall mats were to be placed on the floor beside Resident #4's bed. The CNA stated he/she should have placed the mats on the floor in accordance with directions on the nurse aide's resident care sheet.</p> <p>An interview conducted on 01/18/12, at 9:30 AM, with the Licensed Practical Nurse (LPN) caring for Resident #4 revealed that documentation on the care plan revealed fall mats were to be placed on the floor on each side of Resident #4's bed and confirmed the plan had not been followed.</p> <p>An interview conducted on 01/18/12, at 3:30 PM, with the MDS/Care Plan Nurse revealed the resident had been assessed to have the potential to "roll" out of bed, onto the floor, and confirmed the care plan had not been updated. Based on interview, the nurse on the nursing unit was responsible to update the care plan if the resident experienced a change in care needs. In addition, according to the MDS/Care Plan Nurse, Resident #4 had been assessed to require fall mats at the bedside since 05/09/11.</p> <p>An interview conducted on 01/17/12, at 3:00 PM, with the Director of Nursing (DON) revealed that fall mats were on the CNA and Nursing care plan and should have been on the floor beside the resident's bed.</p>	F 282	<p>Nursing, Assistant Director of Nursing, MDS RN and MDS LPN on 1/18/12. No additional deficient practices were noted.</p> <p><u>Systematic Changes</u></p> <p>Nursing staff was in-serviced during the week of 2/6/12 – 2/10/12 by the Director of Nursing and Assistant Director of Nursing regarding the importance of following care plans and CNA flow sheet. Staff was also reminded to assure safety devices during walking rounds and at shift change.</p> <p><u>Monitoring</u></p> <p>Safety device check audits are to be completed twice a week by the charge nurse on each unit. Results of these audits will be given to the Director of Nursing to present monthly at the Performance Improvement Committee meeting for a period of six months as long as 100% threshold is met. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Consultant Pharmacist, Maintenance Director, Dietary Supervisor, Social Services Director, Admissions Coordinator, Housekeeping/Laundry Supervisor, MDS Coordinator, HR Director and Activities Director.</p>	2/17/12	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 1 (332)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel generator</p> <p>A life safety code survey was initiated and concluded on 01/17/12, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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