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

PRINTED: 06/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185147		C 06/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CENTER	200 STERLING DR. HOPKINSVILLE, KY 42240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey (KY#23288) was conducted on 06/02/15 through 06/05/15. KY #23288 was substantiated with deficiencies cited at the highest Scope and Severity of a "D".	F 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) was free from a physical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. The findings include: Review of the facility's policy titled, "Restraint, use of" revealed restraints shall only be used for the safety and well-being of the resident (s) and only after other alternatives have been tried unsuccessfully. Physical restraints shall only be used upon the order of a physician and after obtaining consent from the resident and/or representative (sponsor), except in emergent situations. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. Physical restraints for behavior control shall only	F 221		

RECEIVED
JUL 2015
OFFICE OF INSPECTOR GENERAL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Frances M Marko
TITLE: Administrator
(X6) DATE: 7-10-15

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

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F 221	Continued From page 1 be used with the order of a physician, except in an emergency which threatens to bring immediate injury to the resident or others. Review of the facility's policy titled, "Informed Consent for Restraint Use", revealed it is the intent of the facility for each resident to attain and maintain his/her highest practicable level in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Record review revealed the facility admitted Resident #1 on 09/29/14 with diagnoses which included Dementia with behavior disturbance, Alzheimer's Disease, Dysthymic Disorder, Altered Mental Status, Depression, and Anxiety. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/27/15, revealed Resident #1's cognition was severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Review of the facility's five (5) day follow up/final report, dated 05/14/15, related to allegation of Abuse/Mistreatment revealed Resident #1 was restrained to his/her wheelchair with a gait belt (not an appropriate restraint) on 05/06/15 at approximately 5:30 PM. Interview with Certified Nursing Assistant (CNA) #1, on 06/04/15 at 8:00 AM, revealed staff was serving the supper meal and Resident #1 got out of his/her wheelchair ambulating without the use of his/her walker. CNA #1 stated the CMT sat with the resident for about forty-five (45) minutes,	F 221	**What corrective action will be accomplished for those residents found to have been affected?** Resident #1 was assessed for use of a Lap Buddy 5/7/2015 and 6/19/2015 on return to facility from Behavioral Health Hospital by R.N. Resident can remove Lap Buddy on request. **How the facility will identify other residents having the potential to be affected by the same deficient practice?** All residents will have MD order, restraint assessment and consent of responsible person prior to use of any restraint except in an emergency situation. Review of clinical notes by Unit Managers for indicators of any restraint use.	7/02/2015

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F 221	Continued From page 2 looking at family pictures and the resident did not get out of wheelchair as long as staff was sitting next to the resident. CNA #1 revealed she observed the staff restrain Resident #1 to his/ her wheelchair with a gait belt on 05/06/15. Interview with CNA #2, on 06/03/15 at 4:00 PM, revealed Resident #1 kept trying to get up without assistance while staff was trying to serve supper trays. CNA #2 stated "the nurse and med tech were feeding residents in room 102 so they used the gait belt to keep the resident in her wheelchair". Interview with Certified Medication Technician (CMT) #1, on 06/03/15 at 8:25 AM, revealed on 05/06/15 at approximately 6:00 PM, a gait belt was used as a restraint to keep Resident #1 from getting out of the wheelchair and ambulating without his/her walker. CMT #1 revealed she assisted Registered Nurse (RN) #1 in applying the gait belt to Resident #1. Interview with Registered Nurse (RN) #1, on 06/05/15 at 9:30 AM, revealed on 05/06/15, Resident #1 was trying to get up and ambulate without the assistance of staff during the supper meal. RN #1 stated CMT #1 sat with the resident for approximately forty-five (45) minutes and looked at pictures and the resident did not try to get up during that time. RN #1 revealed she restrained Resident #1 to his/her wheelchair with a gait belt because staff needed to feed residents and to ensure the resident's safety due to the resident having a fall on 05/05/15. RN #1 stated they placed the resident in Room 102 where her and CMT #1 were feeding residents. However, review of the Physician's Orders and Nursing Notes for 05/06/15 revealed there was no	F 221	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Restraint Policy reviewed and updated on 6/2015 by Director of Nursing, Staff Development Coordinator, Adminnistrator to revise emergency guidelines and include guidelines for Least Restrictive devices. All Nursing staff received in-service education by Staff Development Coordinator and/or Director of Nursing on: 1) Policy for use of Restraints for resident safety; 2) Least Restrictive Device guidelines, and 3) Restraint assessment on 6/25/2015. **How does the facility plan to monitor its performance to ensure that solutions are sustained?** Unit Managers, Staff Development Coordinator and Weekend Supervisor will audit Nurses Notes and MD orders for any restraint without appropriate assessment and documentation 3 times per week. Reported to DON for follow up and report to QA monthly.	

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F 221	Continued From page 3 documented evidence the resident had behaviors that warranted an emergency restraint, was placed in a restraint or an order was received for a restraint (gait belt) per facility policy. In addition, review of Resident #1's assessments and revealed there was no evidence the resident was assessed for a restraint and there was no Informed Consent completed for the use of the gait belt per facility policy. Further record review revealed a a Treatment/Order Update/Change in Condition form for Resident #1, dated 05/06/15 at 11:38 PM, revealed an order for a Lap Buddy PRN (as needed) was received for resident's safety; however, there was no documented evidence a restraint assessment was completed per facility policy. Interview with Director of Nursing (DON), on 06/05/15 at 10:05 AM, revealed she was notified on 05/06/15 at approximately 7:00 PM, Resident #1 was restrained to his/her wheelchair with a gait belt. The DON stated the use of the gait belt as a restraint was not appropriate for an emergency situation. Interview with the Administrator, on 06/05/15 at 10:55 AM, revealed she was notified on 05/06/15 a gait belt was used to restrain Resident #1 to his/her wheelchair for residents' decrease in safety awareness. The Administrator stated, "I feel staff used the least restrictive approach and I would expect staff to use a gait belt as a restraint in an emergent situation".	F 221	Audit during Quality Rounds 3 times weekly of any situation that could be considered a restraint and reported to Unit Managers for assessment and report to QA team (including Director of Nursing, Staff Development Coordinator, Social Services Director, Human Resources, Dietary Manager, Environmental Services Supervisor, Maintenance Supervisor, Medical Director, Office Manager, MDS Coordinator, Medical Records Supervisor and Chaplain) monthly for 6 months or upon recommendation of QA committee. The Director of Nursing is responsible for follow up and recommendations.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 4 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225	**What corrective action will be accomplished for those residents found to have been affected?** Resident #1 was assigned to a different staff member and RN#1 was put on leave 5/7/2015 pending the investigation. **How the facility will identify other residents having the potential to be affected by the same deficient practice?** Any staff member involved in a reported or actual abuse allegation will be removed from the facility until determination of allegation is made by the facility. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** Any allegation of Abuse is reported to employee's supervisor immediately. Supervisor will report to DON and/or Administrator.	7/10/15

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F 225	Continued From page 5 Based on interview, record review, review of the facility's Self Report Incident Form, and review of the facility's Abuse Reporting & Prevention policy, it was determined the facility failed to remove Registered Nurse (RN) #1 (alleged perpetrator) from resident care areas when an allegation of abuse was made for one (1) of three (3) sampled residents (Resident #1). The findings include: Review of the facility's policy titled, "Abuse Reporting & Prevention", not dated, revealed the purpose of this policy was to prevent any type of abuse to residents through pre-employment screening, orientation, and ongoing inservicing of all staff, identification, investigation, protection and reporting, and response. Further review of the facility's policy revealed any report from facility staff, residents, or other persons related to to actual or suspected abuse should be thoroughly investigated by the Administrator and/or designated facility staff. All residents are protected from care by any reported or suspected employee by immediate removal of the employee from resident services areas. The Administrator will determine appropriate actions to prevent further potential abuse or allegations while the investigation is in progress. These actions include removal from the facility work until determination of unsubstantiated abuse is made by the facility Record review revealed the facility admitted Resident #1 on 09/29/14 with diagnoses which included Dementia with behavior disturbance, Alzheimer's Disease, Dysthymic Disorder, Altered Mental Status, Depression, and Anxiety. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/27/15, revealed Resident	F 225	Any staff member that is indicated as perpetrator in an abuse allegation will be removed from the facility immediately and be on leave until a determination is made by investigation of the incident. If the employee involved is determined to be guilty of abuse further corrective action will be taken. All staff including Administrator and Director of Nursing received in-service education on Abuse reporting and prevention by Staff Development Coordinator and Clinical Services Director on 6/25/2015 . All new employees are in-serviced on Abuse Prevention and Reporting in new employee orientation. In-service education of all staff on Abuse Prevention and Reporting is scheduled twice per year. All grievances will be audited for potential abuse, misappropriation of resident property, mistreatment, or neglect and reported to the Administrator for investigation and reporting as dictated by law.	

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F 225	Continued From page 6 #1's cognition was severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Review of the facility's Self Report Incident Form, dated 05/14/15, revealed Certified Nursing Assistant (CNA) #1 reported on 05/06/15 at 6:20 PM that Registered Nurse (RN) #1 was observed grabbing the back of Resident #1's head and pushing the resident forward in the wheelchair. The incident occurred in Room #102 when RN #1 and Certified Medication Technician (CMT) #1 were applying an emergency restraint (seat belt/gait belt) to the resident. Review of RN #1 time card, dated 05/06/15-05/11/15, revealed on 05/06/15, RN #1 worked from 2:39 PM until 12:24 AM on 05/07/15 which indicated the RN remained at work for approximately six (6) hours after the allegation of abuse was made. Interview with RN #1, on 06/05/15 at 9:30 AM, revealed she spoke with the Director of Nursing (DON) by phone on 05/06/15 at approximately 7:00 PM and she was not informed of being implicated in an abuse allegation and was not questioned about the allegation until 05/07/15. RN #1 stated, "I worked on 05/06/15 on the 3:00 PM-11:00 PM shift on the 100 wing the entire shift". Interview with CNA #1, on 06/05/15 at 8:00 AM, revealed she reported an allegation of abuse to the Scheduling Clerk (SC), on 05/06/15 at approximately 6:30 PM by phone. CNA #1 stated RN #1 continued to work in the resident care areas after the allegation of abuse was reported.	F 225	**How does the facility plan to monitor its performance to ensure that solutions are sustained?** Weekly audit of grievances by Staff Development Coordinator and report of compliance and results to QA team (including Director of Nursing, Staff Development Coordinator, Social Services Director, Human Resources, Dietary Manager, Environmental Services Supervisor, Maintenance Supervisor, Medical Director, Office Manager, MDS Coordinator, Medical Records Supervisor and Chaplain) monthly for 6 months or upon recommendation of QA committee. The Director of Nursing is responsible for follow up and recommendations. Interview Audit (see attached) of random employees by Unit Managers, Department Leaders, SDC completed weekly for 2 employees per shift. Audits reported to QA team monthly for follow up and recommendations.	

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F 225	Continued From page 7 Interview with the SC, on 06/05/15 at 9:15 AM, revealed she received a call from CNA #1, on 05/06/15 at 7:00 PM, with an allegation that RN #1 had abused Resident #1. The SC stated she notified the DON of the abuse allegation, on 05/06/15 at approximately 7:10 PM. Interview with the DON, on 06/05/15 at 10:05 AM, revealed she was made aware of the abuse allegation on 05/06/15 at approximately 7:00 PM and she notified the Administrator on 05/06/15 at approximately 7:30 PM. The DON stated "I would expect an allegation of abuse to be reported immediately, if a staff member is accused, that staff member should be removed from resident care areas and a facility investigation will be conducted. RN #1 was not removed from resident care area on 05/06/15 after abuse allegation was reported." Interview with the Administrator, on 06/05/15 at 10:55 AM, revealed any allegation of abuse should be reported directly to DON and until the individual making the allegation reports it to the DON directly, the incident is not considered an abuse allegation. The Administrator stated the SC made the DON aware of the abuse allegation on 05/06/15, and the DON made the her aware of the abuse allegation on 05/06/15. The Administrator stated, "I would have expected CNA #1 to call the DON with the allegation, not the SC, because until the report comes to the DON, it's hearsay, gossip". The Administrator revealed RN #1 remained in resident service area the evening of 05/06/15 because there was not an allegation of abuse at that time. The Administrator further revealed the facility's policy was for any staff member implicated in an abuse allegation to	F 225		

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F 225	Continued From page 8	F 225		
	be removed from resident care area's			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of a facility Self Report Incident Form and the facility Abuse Reporting & Prevention policy, it was determined the facility failed to remove Registered Nurse (RN) #1 (alleged perpetrator) was removed from the resident care areas per facility policy when she was alleged to have abused one (1) of three (3) sampled residents (Resident #1). The findings include: Review of the facility's policy titled, "Abuse Reporting & Prevention", not dated, revealed the purpose of this policy was to prevent any type of abuse to residents through pre-employment screening, orientation, and ongoing inservicing of all staff, identification, investigation, protection and reporting, and response. Further review of the facility's policy revealed any report from facility staff, residents, or other persons related to to actual or suspected abuse should be thoroughly investigated by the Administrator and/or designated facility staff. All residents are protected from care by any reported or suspected	F 226	**What corrective action will be accomplished for those residents found to have been affected?** Resident #1 was assigned to a different staff member and RN#1 was put on leave 5/7/2015 pending the investigation. **How the facility will identify other residents having the potential to be affected by the same deficient practice?** Any staff member involved in a reported allegation or actual abuse allegation will be removed from the facility until determination of unsubstantiated abuse is made by the facility. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** Any allegation of Abuse is reported to employee's supervisor immediately. Supervisor will report to DON and/or Administrator.	7/10/15

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F 226	Continued From page 9 employee by immediate removal of the employee from resident services areas. The Administrator will determine appropriate actions to prevent further potential abuse or allegations while the investigation is in progress. These actions include removal from the facility work until determination of unsubstantiated abuse is made by the facility Record review revealed the facility admitted Resident #1 on 09/29/14 with diagnoses which included Dementia with behavior disturbance, Alzheimer's Disease, Dysthymic Disorder, Altered Mental Status, Depression, and Anxiety. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/27/15, revealed Resident #1's cognition was severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Review of the facility's Self Report Incident Form, dated 05/14/15, and interviews on 06/05/15 with Certified Nurse Aide (CNA) #1 at 8:00 AM, the Scheduling Clerk (SC) at 9:15 AM and the Director of Nursing (DON) at 10:05 AM, revealed CNA #1 reported on 05/06/15 at 6:20 PM to the SC that that she observed RN #1 grabbing the back of Resident #1's head and pushing the resident forward in the wheelchair. The incident occurred in Room #102 when RN #1 and Certified Medication Technician (CMT) #1 were applying an emergency restraint (seat belt/gait belt) to the resident. The SC reported the incident to the DON on 05/06/15 at approximately 7:10 AM and the DON reported the incident to the Administrator at approximately 7:30 PM. Review of RN #1 time card dated 05/06/15-05/11/15 and interview with RN #1	F 226	Any staff member that is indicated as perpetrator in an abuse allegation will be removed from the facility immediately and be on leave until a determination is made by investigation of the incident. If the employee involved is determined to be guilty of abuse further corrective action will be taken. Abuse Prevention and Reporting Policy has been reviewed and updated by Director of Nursing, Administrator, Staff Development Coordinator from date provided to surveyor of January 2012 to June 2015. All staff including Administrator and Director of Nursing received in-service education on Abuse reporting and prevention by Staff Development Coordinator and Clinical Services Director on 6/25 /2015. All new employees are in-serviced on Abuse Prevention and Reporting in new employee orientation. In-service education of all staff on Abuse Prevention and Reporting is scheduled twice per year.	

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F 226	Continued From page 10 06/05/15 at 9:30 AM, revealed RN #1 worked from 2.39 PM until 12:24 AM on 05/07/15 which indicated the RN remained at work for approximately six (6) hours after the allegation of abuse was made. RN #1 stated she spoke with Director of Nursing (DON) by phone on 05/06/15 at approximately 7:00 PM but was not informed of being implicated in an abuse allegation or questioned about the allegation until 05/07/15. RN #1 stated she was not removed from resident care at the time of the allegation on 05/06/15 per the facility's policy. Further interview with the DON, on 06/05/15 at 10:05 AM, revealed she would expect an allegation of abuse to be reported immediately, and if a staff member was accused, the staff member should be removed from resident care areas and a facility investigation should be be conducted per facility policy. The DON stated RN #1 was not removed from resident care area on 05/06/15 after abuse allegation was reported Interview with the Administrator, on 06/05/15 at 10:55 AM, revealed any allegation of abuse should be reported directly to DON and until the individual making the allegation reports it to the DON directly, the incident is not considered an abuse allegation. The Administrator stated the SC made the DON aware of the abuse allegation on 05/06/15, and the DON made her aware of abuse allegation on 05/06/15. The Administrator stated, "I would have expected CNA #1 to call the DON with the allegation, not the SC, because until the report comes to the DON, it's hearsay, gossip". The Administrator revealed RN #1 remained in resident service area the evening of 05/06/15 because there was not an allegation of abuse at that time. The Administrator further revealed the	F 226	All grievances will be audited for any potential abuse, misappropriation of resident property, mistreatment, or neglect and reported to the Administrator for investigation and reporting as dictated by law. **How does the facility plan to monitor its performance to ensure that solutions are sustained?** Weekly audit of grievances by Staff Development Coordinator with report of compliance and results to QA team (including Director of Nursing, Staff Development Coordinator, Social Services Director, Human Resources, Dietary Manager, Environmental Services Supervisor, Maintenance Supervisor, Medical Director, Office Manager, MDS Coordinator, Medical Records Supervisor and Chaplain) monthly for 6 months or upon recommendation of QA committee. The Director of Nursing is responsible for follow up and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185147		C 06/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 11 facility's policy was for any staff member implicated in an abuse allegation to be removed from resident care area's.	F 226	Interview Audit (see attached) of random employees by Unit Managers, Department Leaders, SDC completed weekly for 2 employees per shift. Audits reported to QA team monthly for follow up and recommendations.	