

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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(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 A Recertification Survey was initiated on 10/19/15 and concluded on 10/22/15 with deficiencies cited at the highest scope and severity of an 'E'.	F 000		
F 279 SS-D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to develop a comprehensive care plan for two (2) of twenty-three (23) sampled residents, (Residents #4 and #18). The facility's staff failed to develop care plans to address	F 279 F279	1. The care plans and C.N.A Assignment sheets for residents #4 and #18 were reviewed and updated to include Ted Hose on 10/22/15 by Unit managers. 2. An audit was completed by the Director of Clinical Support on 11/12/15 of all resident's clinical record for physician's orders for Ted Hose. An audit will be completed of the comprehensive care plans and C.N.A. Assignment sheets by Nurse Management to assure all Ted Hose interventions have been added by 11/20/15. 3. The Care Plan P&P was reviewed by the Administrator and Director of Nursing on 11/13/15. An in-service with	12/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Mark E. Witt TITLE _____ DATE _____

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.

FORM CMS-2567(02-99) Previous Versions Obsolete
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If continuation sheet Page 1 of 37

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F 279	<p>Continued From page 1</p> <p>physician ordered Thrombo-Embolec Deterrent (TED) hose for Resident #4 and Resident #18 to be placed in the morning (AM) and removed in the evening (HS).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Nursing Care Planning, not dated, revealed the facility was to maintain a Comprehensive Individualized Care Plan that reflected the resident's current needs. Review of the policy also revealed the Comprehensive Individualized Care Plan would be reviewed for accuracy and adjusted as the resident's needs changed.</p> <p>1. Review of the clinical record for Resident #18 revealed the facility admitted the resident on 04/22/14 with diagnoses of Essential Hypertension, Type 2 Diabetes, Chronic Pain, Vitamin B-12 Deficiency Anemia, a History of Pulmonary Embolus, Unspecified Atrial Fibrillation (Arrhythmia), Congestive Heart Failure, and insomnia.</p> <p>Review of Resident #18's physician orders revealed an order, dated 11/04/14 and ongoing, for the application of knee-high TED hose to be placed on the resident's legs in the morning (AM), and to be removed at bedtime (HS).</p> <p>Review of Resident #18's comprehensive care plan, dated 05/15/14-Present, did not reveal the application of the TED hose was listed under any component within the resident's care plan.</p>	F 279	<p>Licensed Nurses will be completed on the Care Plan P & P by 12/2/15 by the Director of Nursing. The Nurse Managers were re in-serviced on 11/13/15 by the Director of Nursing to audit all new orders 5 times weekly to ensure changes in Physician orders have been care planned on the Comprehensive care plan and the C.N.A. Assignment sheets. Based on these audits the Nurse Managers will update the care plans and the CNA sheets accordingly. These audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 2 months, then as recommended by the QAPI committee.</p>	
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F 279	Continued From page 2. Review of the 100 Hallway Certified Nursing Assistant (CNA) assignment sheet (not dated), revealed the application of TED hose was not listed as a care intervention for Resident #18. Observation, on 10/22/15 at 10:55 AM, revealed Resident #18 was seated in his/her room, in a wheelchair and dressed in street clothes with slip-on moccasin style shoes on his/her feet. Resident #18's legs were visible from the knees down, and he/she did not have on TED hose. Observation, on 10/22/16 at 11:25 AM, revealed Resident #18 was seated in his/her room in a wheelchair, talking with a visitor. Resident #18 continued to wear the moccasin style shoes, but again he/she did not have on TED hose. Additional observation revealed two (2) knee-length TED hose draped over a straight backed chair near Resident #18's bed. Interview, on 10/22/15 at 11:05 AM, with CNA #1 revealed she was assigned to provide Resident #18's daily care, and that the resident typically needed assistance with incontinence care, placing his/her bilateral hearing aids, and grooming. CNA #1 stated Resident #18 did not require TED hose. Interview, on 10/22/15 at 11:20 AM, with Licensed Practical Nurse (LPN) #1 revealed he was assigned to the 100 Hallway to administer the residents' medications, but he stated he had access to treatment orders including orders for	F 279	4. The results of the audits will be reported to the QAPI Committee monthly for 4 consecutive months, then as recommended by the QAPI Committee. <u>Addendum</u> F279 11/19/15 (NN) #3. These audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 months, then as recommended by the QAPI committee. #4 The results of the audits will be reported by Director of Nursing to the QAPI Committee monthly for 6 consecutive months, then as recommended by the QAPI Committee to ensure continued compliance.	12/5/15

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F 279	<p>Continued From page 3</p> <p>the application of assistive devices and other required treatments. LPN #1 stated he recently starting working at the facility, and that he was an agency nurse. LPN #1 stated since he had not worked very long on the 100 hallway, the Unit Manager (UM) had been helping him out with the residents' treatments/assistive devices. LPN #1 stated Resident #18 had an order for TED hose, and his interpretation of the order was direct care staff had a two (2) hour window from the time Resident #18 awakened to apply the TED hose. However, LPN #1 stated the nurse assigned to a resident with an order for TED hose should ensure the TEDs had been put on the resident as ordered.</p> <p>Interview, on 10/22/15 at 11:28 AM, with the 100 Hallway UM revealed the TED hose order was current, and that Resident #18 should have had the TED hose on when he/she was out of bed. In addition, the licensed nurse assigned to care for Resident #18 should have informed CNA #1 that Resident #18 had TED hose and that they were to be applied to the resident's legs each morning when he/she was transferred from bed. The UM stated that upon review of the CNA assignment sheet, she did not see the TED hose listed as one of Resident #18's care interventions.</p> <p>Interview, on 10/22/15 at 1:45 PM, with the Minimum Data Set (MDS) Registered Nurse (RN) revealed after a newly admitted resident was assessed, a care plan would be developed. It should be comprehensive and meet the resident's needs. The care plan should include physician ordered interventions, and if TED hose were ordered, a care plan should have TED hose listed</p>	F 279		

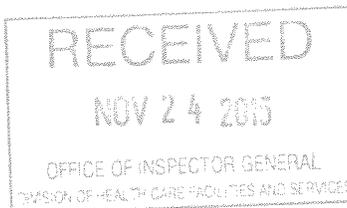
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F 279	<p>Continued From page 4</p> <p>as a care intervention. The MDS Nurse stated when licensed nurses received physician orders, they were to add that information to the 24-hour nursing report. The Director of Nursing (DON) reviewed the 24-hour report for any new orders received over the 24-hour period, and then the Unit Managers developed a care plan or updated the existing care plan, as appropriate. Based on the physician's orders, the care plan should describe the nursing care necessary to ensure the orders were followed. The CNA assignment sheet should reflect the care and monitoring the CNA should provide for the resident.</p> <p>Interview, on 10/22/15 at 2:15 PM, with the 100 Hallway UM revealed it was her responsibility as UM to ensure the residents on her hallway had care plans that were developed and updated to reflect physician's orders and any related care needs. The UM stated it would be helpful for Resident #18's CNA to be aware the resident was to have TED hose applied, via the CNA assignment sheet, but the licensed nurse was ultimately responsible for ensuring the TED hose were applied, and for documenting their application within the resident's Treatment Administration Record (TAR).</p> <p>2. Review of Resident #4's clinical record revealed the facility admitted Resident #4 on 01/27/15, with diagnoses of Hypertension, Epilepsy, Anemia, Dementia Without Behavioral, Major Depressive Disorder, Allergy Unspecified, and Myoclonus.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/09/15, revealed the facility assessed the resident with a Brief Interview for</p>	F 279		



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F 279	<p>Continued From page 5</p> <p>Mental Status (BIMS) with a score of three (3), which indicated the resident was unable to complete the interview.</p> <p>Review of a Treatment Order, electronically signed and dated 05/28/15, revealed a verbal order was received from Resident #4's physician to apply bilateral knee high TED Hose to the resident twice a day. The Treatment Order read the TED Hose were to be on in the mornings and off at bed time.</p> <p>Review of Resident #4's Comprehensive Care Plan, dated 02/05/15, revealed there was no evidence to show the facility addressed the physician's order to apply TED Hose to Resident #4 twice a day on the Comprehensive Care Plan nor the Certified Nursing Assistant's (CNA's) assignment sheets.</p> <p>Observation, on 10/20/15 at 1:11 PM, revealed Resident #4 was seated in his/her wheelchair in the television area on the 2nd Floor and he/she was eating lunch at the dining table. Observation also revealed Resident #4 had on non-skid socks, but no TED hose.</p> <p>Observation, on 10/20/15 at 3:05 PM, revealed Resident #4 was seated in his/her wheelchair watching television with two other residents in the television area on the 2nd Floor. Resident #4 continued without TED hose on underneath his/her non-skid socks.</p> <p>Observation, on 10/21/15 at 8:53 AM, revealed Resident #4 was self-propelling down the hallway into his/her bedroom dressed for the day in pants, shirt, and a sweater, and without TED hose on underneath his/her non-skid socks.</p>	F 279		

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F 279	Continued From page 6 Interview with Licensed Practical Nurse (LPN) #3, on 10/21/15 at 4:16 PM, revealed a nurse who received the order from a physician to apply TED hose to a resident, should have updated the careplan to reflect the new order. LPN #3 stated the CNA Assignment sheet should also be updated to reflect the new order to apply TED hose to the resident. LPN #3 also stated if the resident's care plan or CNA assignment sheet wasn't updated the physician's order wouldn't be completed and the nursing staff wouldn't know how to appropriately care for the resident. Interview with the 2B Nurse Manager, on 10/21/15 at 4:36 PM, revealed after a nurse had received a verbal treatment order from a physician to apply TED hose to a resident it should be placed in the computer under treatments by the nurse with direction on how to apply the TED hose. The 2B Nurse Manager stated she did not know if a care plan should have been developed for the physician's order to apply TED hose. Interview with the MDS Nurse, on 10/21/15 at 5:00 PM, revealed when the verbal order from the physician was received to apply TED hose to a resident the care plan should have been developed immediately. The MDS nurse stated the nurse that took the verbal order from the physician to apply TED hose to a resident was responsible to develop the care plan. The MDS nurse further stated the initiation of a care plan was a crucial part of correctly treating the resident. Interview with the Director of Nursing (DON), on 10/22/15 at 10:11 AM, revealed a care plan	F 279		

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F 279	Continued From page 7 should have been developed to address the physician's verbal order to have TED hose applied to Resident #4 twice a day by the nurse manager. The DON stated it was the responsibility of the nurse manager to develop the care plan on a day-to-day basis and to update the Treatment Administration Record (TAR) and CNA Assignment Sheets. The DON also stated she had trained staff to follow the facility's policy and procedure regarding Nursing Care Plans, but she did not verify each order had been care planned appropriately. The DON also stated if a resident's treatment was not care planned the staff would not be able to address the resident's needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 1. Resident # 5 – Physician orders were reviewed for skin interventions including elevate heels on 11/12/15 by the Director of Clinical Support. The residents care plan and C.N.A. Assignment sheet were reviewed and updated on 11/13/15 by the Unit Manager. 2. An audit was completed of all resident's clinical record for Physician's Orders for skin interventions including to elevate heels on 11/12/15 by	12/5/15

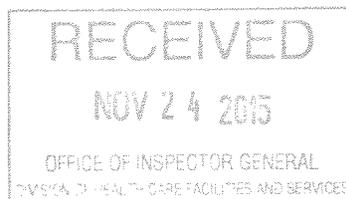
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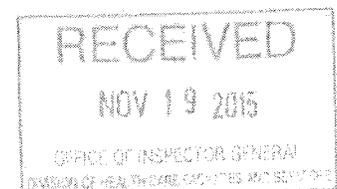
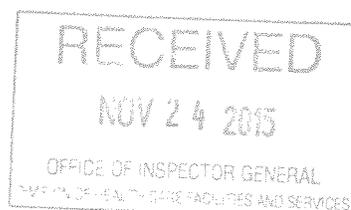
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F 280	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to revise the interim care plan for one (1) of twenty-three (23) sampled residents, Resident #5. The staff failed to revise the care plan to include elevating Resident #5's heels off the bed per physician orders to relieve and prevent pressure. The findings include: Review of the facility's Care Planning Policy, not dated, revealed upon admission an Interim Care Plan would be completed by the admitting nurse and or Nurse Manager to reflect current needs. Licensed nurses would revise the Interim Care Plan with any changes in care until the Comprehensive care plan was completed. Review of the Clinical Record for Resident #5, revealed the facility admitted the resident on 10/15/15 with diagnoses of Pressure and Vascular Wounds. Review of Resident #5's, Physician Orders, dated 10/17/15, revealed Resident #5's heels were to be elevated and kept off of the bed. Review of Resident #5's, Initial Care Plan, dated 10/15/15, revealed the staff was to complete treatments as ordered for pressure wounds. Review of Resident #5's, Certified Nursing	F 280	the Director of Clinical Support. An audit will be completed of all care plans and C.N.A. Assignment sheets to assure skin interventions including to elevate heels has been placed as an intervention per Physician's Order on by Nurse Managers by 12/2/15. 3. The Care Plan P&P that includes revision of the care plan was reviewed by the Administrator and Director of Nursing on 11/13/15. An in-service with Licensed Nurses will be completed on Revising a Care Plan by 12/2/15 by the Director of Nursing. The Nurse Managers were re in-serviced on 11/13/15 by the Director of Nursing to audit all new orders 5 times weekly to ensure changes in Physician orders have been care planned on the	



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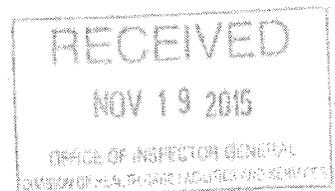
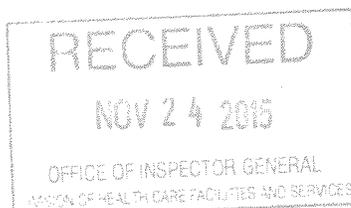
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F 280	<p>Continued From page 9</p> <p>Assistant (CNA) care plan, not dated, revealed no documentation for the treatment of keeping Resident #5's heels elevated of the bed.</p> <p>Observations of Resident #5, on 10/20/15 at 2:38 PM and 3:28 PM, on 10/21/15 at 8:30 AM, 10:25 AM and on 10/22/15 at 9:12 AM, revealed Resident #5 was lying down on his/her bed with feet not elevated off the bed.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 10/22/15 at 12:45 PM, revealed she was not aware Resident #5's feet were to be elevated and had not elevated Resident #5's heels. CNA #3 stated if the treatment was not documented on her CNA Care Plan she would not know to complete the task. CNA #3 stated the nursing staff provided them with the CNA Care Plan at the beginning of every shift.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 10/22/15 at 12:20 PM, revealed the nursing staff initiated the care plan and the supervisors completed the care plans and added new orders to the care plans as needed. LPN #5 stated staff were expected to follow the care plans as directed and elevate Resident #5's heels off the bed.</p> <p>Interview with the Rehab Unit Manager, on 10/22/15 at 1:54 PM, revealed she was responsible for revising the CNA Care Plans daily. The Rehab Unit Manager was also responsible to revise the Nursing Care Plans with the new orders that were ordered by the Physician. The Rehab Unit Manager stated she expected the staff to follow the care plans and if the treatment</p>	F 280	<p>Comprehensive or Interim care plan and the C.N.A. Assignment sheets. Based on these audits the Nurse Managers will update the care plans and the CNA sheets accordingly. These audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 2 months, then as recommended by the QAPI committee.</p> <p>4.) The results of the audits will be reported to the QAPI Committee monthly for 4 consecutive months, then as recommended by the QAPI Committee.</p> <p><u>Addendum</u> 11/19/15 (RM) F280 #3 These audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4</p>	12/5/15



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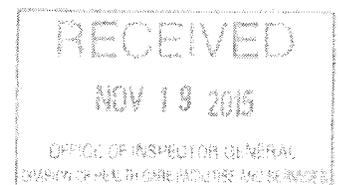
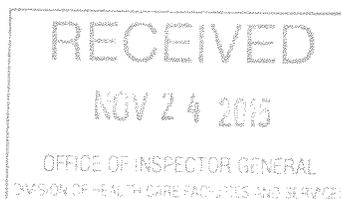
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203	
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F 280	Continued From page 10 was not documented on the CNA Care Plan the staff would not know to complete the task and as a result cause the wound to Resident #5's left foot to become worse. Interview with the Minimum Data Set (MDS) Coordinator, on 10/22/15 at 12:55 PM, revealed she completed the comprehensive care plan. The Admission Nurse would complete the Admission Care Plan. The MDS Coordinator stated she did not revise the CNA Care Plans and staff was expected to follow the care plans as directed. Interview with the Director of Nursing (DON), on 10/22/15 at 2:10 PM, revealed the CNA Care Plans were updated by the Unit Secretary. The CNA's looked at the CNA Care Plans to see how to take care of the resident they were assigned to for the day. The DON stated the nursing staff was ultimately responsible for the care being given.	F 280	F280 Addendum (cont.) (MW) 11/19/15 months, then as recommended by the QAPI committee. #4. The results of the audits will be reported by the Director of Nursing to the QAPI Committee monthly for 6 consecutive months, then as recommended by the QAPI Committee to ensure continued compliance..	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to follow physician orders for two (2) of	F 309 F309	1. The care plans for resident's #4 and #18 was updated to include Ted Hose as an intervention on 10/22/15 by a Nurse Manager. The CNA Assignment sheet was updated to include the application and removal of Ted Hose on 10/22/15 by a nurse Manager. Ted hose were placed as ordered on the residents on 10/22/15.	12/5/15



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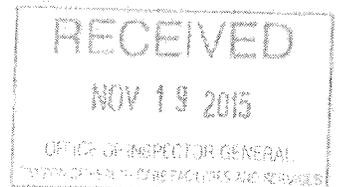
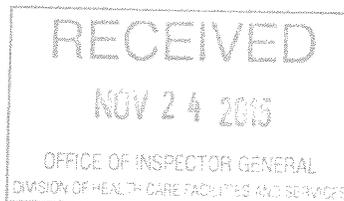
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F 309	<p>Continued From page 11</p> <p>Twenty-three (23) sampled residents, (Residents #4 and #18). The facility's direct care staff did not apply Resident #4's nor Resident #18's Thrombo-Embotic Deterrent (TED) hose as ordered by the physician.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Physician's Orders, not dated, revealed the the Physician's Order would be followed as directed for the duration of the order.</p> <p>1. Review of the clinical record for Resident #18, revealed the facility admitted the resident on 04/22/14 with diagnoses of Essential Hypertension, Type 2 Diabetes, Chronic Pain, Vitamin B-12 Deficiency Anemia, a History of Pulmonary Embolus, Unspecified Atrial Fibrillation (Arrhythmia), Congestive Heart Failure, and Insomnia.</p> <p>Review of Resident #18's physician's orders revealed an order, dated 11/04/14 and ongoing, for the application of knee-high TED hose to be placed on the resident's legs in the morning (AM), and they were to be removed at bedtime (HS).</p> <p>Observation, on 10/22/15 at 10:55 AM, revealed Resident #18 was seated in his/her room, in a wheelchair and dressed in street clothes, with slip-on moccasin style shoes on his/her feet. Resident #18's legs were visible from the knee down, and he/she did not have on TED hose.</p> <p>Observation, on 10/22/15 at 11:25 AM, revealed Resident #18 was seated in his/her room in a wheelchair, talking with a visitor. Resident #18 continued to wear the moccasin style shoes, but</p>	F 309	<p>2. An audit was completed by the Director of Clinical Support on 11/12/15 of all resident's clinical record for physician's orders for Ted Hose. An audit will be completed of the comprehensive care plans and C.N.A. Assignment sheets by Nurse Management to assure all Ted Hose interventions have been added by 11/20/15. A resident observation was completed by a licensed nurse to assure the Ted Hose are on and in place for any resident who has a Physician's Order on 11/13/15.</p> <p>3. An in-service with Licensed Nurses will be completed on the P&P for following a Physician's Order and Documentation including to only document after completion of a physicians order by the Director of Nursing by 12/2/15. The Nurse</p>		



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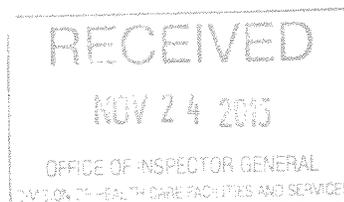
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 820 SOUTH FOURTH 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 309	<p>Continued From page 12 again he/she did not have on TED hose. Additional observation revealed two (2) knee-length TED hose draped over a straight backed chair near Resident #18's bed.</p> <p>Interview, on 10/22/15 at 11:05 AM. with Certified Nursing Assistant (CNA) #1 revealed she was assigned to provide Resident #18's daily care, and that the resident typically needed assistance with incontinence care, placing his/her bilateral hearing aids, and grooming. CNA #1 stated Resident #18 did not require TED hose.</p> <p>Review, of the 100 Hallway CNA assignment sheet (not dated), revealed the application of TED hose was not listed as a care intervention for Resident #18.</p> <p>Interview, on 10/22/15 at 11:20 AM, with Licensed Practical Nurse (LPN) #1 revealed he was assigned to the 100 Hallway to administer the residents' medications, but he also had access to the residents' physician's orders, including orders for the application of assistive devices and other required treatments. LPN #1 stated since he came to the facility to work as an agency nurse, and had not worked very long on the 100 hallway, the 100 Hallway Unit Manager (UM) had been helping him out with the residents' treatments and assistive devices. LPN #1 stated Resident #18 had an order for TED hose, and his interpretation of the order was direct care staff had a two (2) hour window from the time Resident #18 awakened to apply the TED hose. LPN #1 stated the nurse assigned to a resident with an order for TED hose should</p>	F 309	<p>Managers were in-serviced on 11/13/15 by the Director of Nursing to audit any resident who has an order for Ted Hose to ensure they have been applied per physicians order. These audits will be completed 10 times per week times 4 weeks, then 5 times weekly times 3 weeks, then weekly times 2 months, then as recommended by the QAPI Committee.</p> <p>4. These audits will be reported to the Quality Assurance Committee monthly for 4 consecutive months, then as recommended by the QAPI Committee.</p>	



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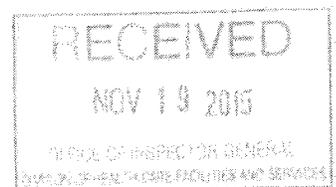
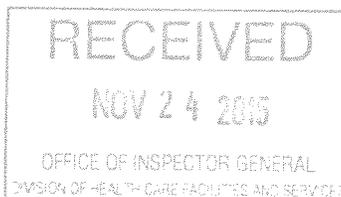
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203		
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F 309	<p>Continued From page 13</p> <p>ensure the TEDs had been put on the resident as ordered.</p> <p>Interview, on 10/22/15 at 11:35 AM and 12:35 PM, with the 100 Hallway UM, revealed the facility's "smart board," alert system made the licensed nurses aware of each resident's daily treatments and needs for assistive devices such as TED hose. The nurse assigned to the 100 Hallway should have ensured Resident #18's hose were applied as ordered. Further, the UM stated the TED hose order was current, and that Resident #18 should have had the TED hose on when he/she was out of bed. In addition, the licensed nurse assigned to care for Resident #18 should have made CNA #1 aware that the TED hose were to be applied to the resident's legs each morning before the resident was transferred from bed, but that upon review of the CNA assignment sheet, she did not see the TED hose listed as a care intervention for Resident #18.</p> <p>2. Review of Resident #4's clinical record revealed the facility admitted Resident #4 on 01/27/15, with diagnoses of Hypertension, Epilepsy, Anemia, Dementia Without Behaviors, Major Depressive Disorder, Allergy Unspecified, and Myoclonus.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/09/15, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) with a score of three (3), which meant the resident was unable to complete the interview.</p>	F 309	<p><u>Addendum</u></p> <p>F309 11/19/15 (MW)</p> <p>#3 These audits will be completed 10 times per week times 4 weeks, then 5 times weekly x 3 weeks, then weekly x 4 months, then as recommended by the QAPI Committee.</p> <p>#4 These audits will be reported by the Director of Nursing to the Quality Assurance Committee monthly for 6 consecutive months, then as recommended by the QAPI Committee to ensure continued compliance.</p>		12/5/15



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F 309	<p>Continued From page 14</p> <p>Review of the Treatment Orders, electronically signed and dated 08/26/15, revealed a verbal order was received from Resident #4's physician to apply bilateral knee high TED Hose to the resident twice a day. The Treatment Order read the TED Hose were to be on in the mornings and off at bed time.</p> <p>Observation, on 10/20/15 at 1:11 PM, revealed Resident #4 was seated in his/her wheelchair in the television area on the 2nd Floor and he/she was eating lunch at the dining table. Observation also revealed Resident #4 had on non-skid socks, but no TED hose.</p> <p>Observation, on 10/20/15 at 3:05 PM, revealed Resident #4 was seated in his/her wheelchair watching television with two other residents in the television area on the 2nd Floor. Resident #4 continued without TED hose on underneath his/her non-skid socks.</p> <p>Observation, on 10/21/15 at 8:53 AM, revealed Resident #4 was self-propelling down the hallway into his/her bedroom dressed for the day in pants, shirt, and a sweater, without TED hose on underneath his/her non-skid socks.</p> <p>Interview with Certified Nurse Assistant (CNA) #2, on 10/21/15 at 9:40 AM, revealed she was assigned to Resident #4 regularly and was familiar with Resident #4's daily routine. CNA #2 stated she had never placed TED Hose on Resident #4 in the seven (7) months she had been employed by the facility. CNA #2 also stated when a resident was required to wear TED hose, it would be listed on the CNA assignment sheet and the nurse would remind her to put TED hose on the resident. CNA #2 further stated a</p>	F 309		



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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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F 309	Continued From page 15 physician's order was required to apply TED hose. CNA #2 stated that the purpose for TED hose was to prevent swelling and discoloration of the legs and if a resident did not have the TED hose on as ordered their legs could swell and cause pain. Interview with Licensed Practical Nurse (LPN) #3, on 10/21/15 at 4:16 PM, revealed a nurse would need an order from a physician to apply TED hose to a resident. LPN #3 stated Resident #4's physician had ordered him/her to have TED hose on in the morning and to remove the TED hose before he/she went to bed. LPN #3 also stated the CNA had placed TED hose on Resident #4 and she had visually verified that the TED hose were actually on Resident #4. LPN #4 stated she had documented the application of TED on Resident #4 in the electronic treatment record because CNAs did not document in the resident's treatment record. LPN #3 further stated that after a physician's order was received it was the nursing staff's responsibility to follow through as directed and if the orders weren't followed for the placement of TED hose the resident could have complications of swelling or a blood clot. Interview with the 2B Nurse Manager, on 10/21/15 at 4:36 PM, revealed that after a nurse had received an order from a physician to apply TED hose to a resident the order should be followed as directed. The 2B Nurse Manager stated that after she saw Resident #4 had returned from breakfast without his/her TED hose on as ordered she had CNA #2 to assist her to put the TED hose on the resident. The 2B Nurse Manager also stated the CNA should have placed the TED hose on Resident #4 when she dressed him/her to go down for breakfast. The 2B Nurse	F 309		
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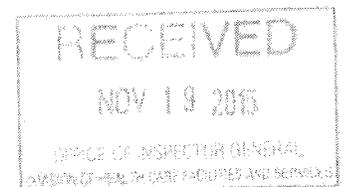
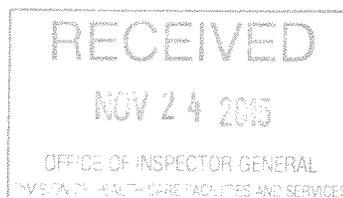
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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F 309	Continued From page 16 Manager further stated the TED hose were ordered by the physician to prevent swelling.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure physician ordered treatments were completed for one (1) of	F 314	1. The care plan and CNA Assignment sheet for resident #5 was updated to include elevation of the heels per the Physician's Orders on 10/22/15. A Licensed nurse observed the resident on 10/22/15 to ensure heels were being elevated.	12/5/15



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F 314	<p>Continued From page 17</p> <p>Twenty-three (23) sampled resident. (Resident #5). The staff failed to ensure Resident #5's bilateral heels were elevated off the mattress to reduce pressure.</p> <p>The findings include:</p> <p>Review of the Pressure Ulcer Prevention Policy, not dated, revealed to implement individualized interventions to attempt to stabilize, reduce or remove underlying risk factors.</p> <p>Review of the Clinical Record for Resident #5, revealed the facility admitted the resident on 10/15/15 with diagnoses of Muscle Weakness, Abnormality of Gait and Mobility, Difficulty Walking, Diabetes Type 2, Long Term Anticoagulant Therapy and Pressure and Vascular Wounds.</p> <p>Review of Resident #5's, Admission Assessment, dated 10/15/15, revealed the facility admitted the resident with an unstageable pressure ulcer to the left lower heel measuring four (4) centimeters (cm) in length and four (4) cm in width.</p> <p>Review of Resident #5's, Physician Orders, dated 10/17/15, revealed Resident #5's heels were to be elevated and kept off of the resident's bed.</p> <p>Review of Resident #5's, Initial Care Plan, dated 10/15/15, revealed the staff was to complete treatments as ordered.</p> <p>Review of Resident #5's, Certified Nursing Assistant (CNA) care plan, no date provided, revealed there was no documentation for the treatment of keeping Resident #5's heels elevated off the mattress.</p>	F 314	<p>2. An audit will be completed of all resident's clinical record for Physician's Orders for elevating heels off of the bed on 11/12/15 by the Director of Clinical Support. An audit will be completed of all care plans to assure that skin interventions including elevating heels has been placed as an intervention per Physician's Order by 12/2/15. An audit of all CNA Assignment sheets will be completed to assure that skin interventions including elevating heels is included on all residents who have a Physician's order on 11/13/15.</p>	

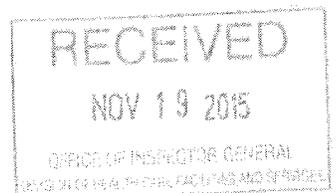
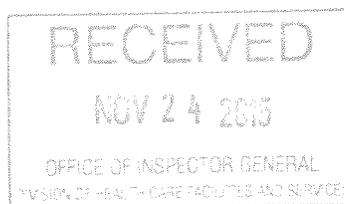
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F 314	Continued From page 18 Observations of Resident #5, on 10/20/15 at 2:38 PM and 3:28 PM, on 10/21/15 at 8:30 AM, and 10:25 AM, and on 10/22/15 at 9:12 AM, revealed Resident #5 was lying down in bed with no pillows under the feet or boots on the feet to elevate off the mattress. Review of Resident #5's, Wound Assessment, dated 10/21/15, revealed there was still an unstageable pressure wound to Resident #5's left heel measuring four (4) cm in length and four (4) cm in width. Interview with Certified Nursing Assistant (CNA) #3, on 10/22/15 at 12:45 PM, revealed the CNA care card informed her of how a resident transferred, when their showers were to be given, if the resident was a falls risk and any alarms. CNA #3 stated if the treatment was not documented on her CNA care plan she would not know to do the care needed for the resident. CNA #3 stated the nursing staff provided the CNA care sheets to them in the morning of each shift. Interview with Licensed Practical Nursing (LPN) #6, on 10/22/15 at 12:20 PM, revealed it was the nurses and CNA's responsibility to ensure Resident #5's feet were up on pillows. Resident #5's feet were to be elevated to prevent and relieve pressure to his/her heels. Interview with the Rehab Unit Manager, on 10/22/15 at 1:54 PM, revealed Resident #6 had an order to keep heels elevated and off of the resident's bed, to prevent further pressure and development of new wounds. Though the wound did not change, the wound could become worse	F 314	3. An in-service will be completed with all Licensed Nurses on the P&P for following a Physician's order and New Admission Care plans, and Wound Prevention by 12/2/15. The Nurse Managers were In-serviced 11/13/15 by the Director of Nursing to audit New Admissions orders, care plans, CNA Assignment Sheets, and following Physicians orders. These audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 2 months, then as recommended by the QAPI Committee. 4. The results of the audits will be reported to the Quality Assurance Committee monthly for 4 consecutive months, then as recommended by the QAPI Committee.	



Addendum

F314 11/19/15 (MW)

Completion Date

12/5/15

#2 One resident was found to not have their Heelz up cushion in place by Director of Clinical Support. Intervention was placed immediately and staff educated by Director of Nursing on 11/13/15.

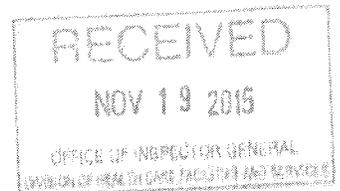
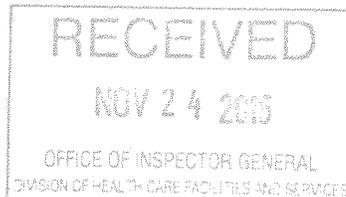
The unit manager will perform the care plan audits.

The unit manager will perform the certified nursing aide assignment sheet audit.

#3 An In-service given by the Director of Nursing will be completed with all Licensed Nurses on the P&P for following a Physician's order and New Admission Care plans, and Wound Prevention by 12/2/15.

These audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 months, then as recommended by the QAPI Committee.

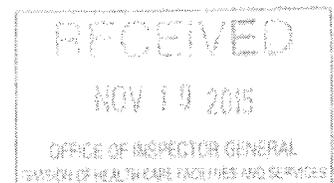
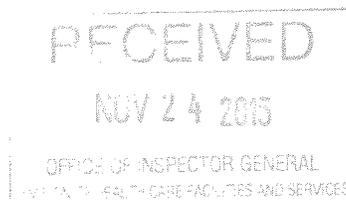
The results of the audits will be reported by the Director of Nursing to the Quality Assurance Committee monthly for 6 consecutive months, then as recommended by the QAPI Committee to ensure continued compliance.



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F 314	Continued From page 19 due to lack of treatment and not keeping Resident #5's feet elevated. Interview with the Director of Nursing (DON), on 10/22/15 at 2:10 PM, revealed the CNA's looked at the CNA care plan to see how to take care of the residents. The DON stated the nurses were ultimately responsible to ensure the care was being provided to the residents. The DON stated there had not been any breakdown of skin, but it could occur if the treatment was not being provided.	F 314	Addendum 11/19/15 F314 Added to extra page that follows this page	
F 323 33=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy review, and review of the facility's Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible for two (2) of four (4) utility closets containing hazardous chemicals. The Central Supply Rooms contained sharps and one supply room was observed unlocked and accessible to residents. The findings include:	F 323	F323 1.) All existing locks identified as being found in deficient practice were verified by Housekeeping Director to be in working order on 10/23/15. 2.) All other storage areas in the facility including the Central Supply were checked by Housekeeping Director to ensure they all had functioning secured locks on 10/23/15.	12/5/15



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F 323	<p>Continued From page 20</p> <p>Review of the facility's policy regarding Hazardous Chemicals Storage and Security, dated 08/30/02, revealed all hazardous chemicals storage closets must be kept locked and/or secured at all times, unless a staff member was present.</p> <p>The facility did not provide a policy on storage of sharps.</p> <p>Observation during the initial facility tour, on 10/19/15 at 3:45 PM, revealed the central supply room door accessible to residents was unlocked. The room was located in the hall near the activities room. The room contained an office located to the right of entering the room. Further observation of the supply room revealed storage of tuberculin needles, 20 gauge hypodermic needles, and suture removal kits containing scissors. The room also contained other care items such as briefs, boxes of gloves, dressing supplies, and shampoo. Staff was not present in the room or office during the observation.</p> <p>Observation of the Transitional Rehab to Home (TRH) hall, on 10/21/15 at 12:16 PM, revealed a utility closet door opening onto the main hallway and accessible to residents was unlocked. The closet door had a sign posted on it that read, "Biohazard." Further observation of the utility closet revealed storage of cleaning chemicals that included: one (1) container of Ecolab Glass Cleaner; one (1) container of Disinfecting Heavy Duty Acid Bathroom Cleaner; one (1) container of Oasis Morning Breeze; and one (1) container of Maxx Dual Floor cleaner. The closet also contained paper towels, toilet paper, and plastic garbage bags.</p>	F 323	<p>3.) All four housekeeping supply closets on resident areas, along with the Central supply storage room, and an additional dietary storage room in a resident area have had a new-style lock ordered as a replacement lock to turn those doors into having an automatic lock that is unable to be bypassed. These locks have been ordered on 11/11/15 from Klein Bros. Lock Company (Job order #477134) and installed, completed on 11/12/15.</p> <p>Education was provided on 10/23/15 from Administrator, to Housekeeping Director, and Central Supply Coordinator about Accidents and Hazards specifying that all storage areas containing any possible hazard to a resident must be locked at all times when physically unattended. Housekeeping Director educated his entire staff on same subject - to be</p>		

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F 323	<p>Continued From page 21</p> <p>Review of the facility's MSDS for the cleaner, Ecolab Glass Cleaner, dated 01/10/13, revealed the chemical may cause eye irritation.</p> <p>Review of the facility's MSDS for the cleaner and disinfectant, Disinfecting Heavy Duty Acid Bathroom Cleaner, dated 11/11/13, revealed the chemical was harmful if swallowed and caused severe skin burns and eye damage.</p> <p>Review of the facility's MSDS for the air freshener, Oasis morning Breeze, dated 05/29/13, revealed the chemical caused serious eye irritation.</p> <p>Review of the facility's MSDS for the floor cleaner, Maxx Dual Action Floor Cleaner, dated 10/01/13, revealed the chemical caused severe skin burns and eye damage. In addition, it may cause respiratory irritation.</p> <p>Review of the facility's MSDS for the cleaning product, Stride Citrus, dated 06/24/06, revealed the product may be mildly irritating to the eyes and skin.</p> <p>Review of the facility's MSDS for the multi-surface cleaner, Keystone Vigoroso Lavender Multi-Surface Cleaner, dated 08/05/13, revealed the product caused eye irritation.</p> <p>Review of the facility's MSDS for the disinfectant, Disinfectant Cleaner 2.0, dated 03/27/13, revealed the product was harmful if contact to the skin and caused serious eye irritation.</p> <p>Interview with Housekeeper #3, on 10/22/15 at 9:12 AM, revealed she was trained to always keep the utility closet doors locked. She stated</p>	F 323	<p>completed by 11/18/15. All new Housekeeping staff will be educated in orientation on the facility policy to keep all storage areas containing any possible hazard to a resident must be locked at all times when physically unattended.</p> <p>4.) As part of QA process, Housekeeping Director, will monitor that all storage locks in facility are functioning properly weekly X 4 weeks, bi-weekly X two months, then as recommended by the QAPI Committee. These audits will be presented to the QAPI committee to ensure compliance.</p>	

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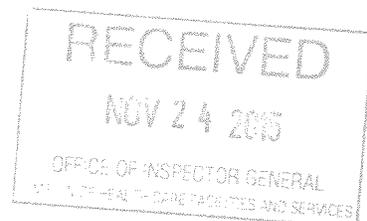
Addendum - 11/23 (AW)

F323

#1. The doors cited as being unlocked were secured and locked by Housekeeping Director on 10/23/15

#3. In addition to all Housekeeping staff, and Central Supply staff education provided - the Director of Nursing will provide education to all staff that have access to the keys, Nurse Supervisors and Security Guard team, on the facility policy to keep all storage areas containing any possible hazard to a resident must be locked at all times when physically unattended. This education will be completed by 12/2/15. Any new Nurse managers or Security Guards will have education provided during orientation process.

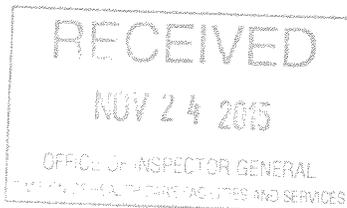
#4. As part of QA process, Housekeeping Director, will monitor that all storage locks in facility are functioning properly weekly X 2 months, bi-monthly x four months, then as recommended by the QAPI Committee. The Director of Housekeeping shall report the audit results for 6 months to monthly QAPI committee meeting.



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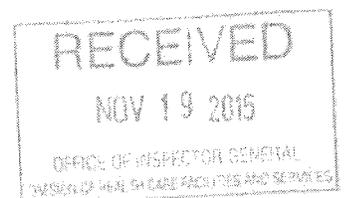
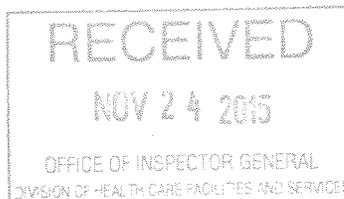
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F 323	<p>Continued From page 22</p> <p>the chemicals would be harmful to residents if they ingested them or got them in their eyes.</p> <p>Interview with the Housekeeping Supervisor, on 10/22/15 at 8:40 AM, revealed he had a key to the central supply room, but did not store any chemicals there. He stated the room was sometimes unlocked when staff was present in the office. However, the utility closets were to be kept locked at all times. He stated the housekeepers were trained to keep the doors locked. He stated the chemicals stored in the closets would be harmful to the residents if they were ingested. Further interview at 2:05 PM, revealed he did not routinely monitor the utility closet doors to make sure they were locked.</p> <p>Interview with the Staffing Coordinator/Central Supply, on 10/22/15 at 9:30 AM, revealed her normal working hours were 7:00 AM-3:00 PM. She stated she was in the office except when she assisted with passing meal trays and ice. She stated the central supply door locked automatically. She stated the door could remain unlocked by turning the knob on the inside of the door handle. She stated she made sure the door was locked when she left for the day. She further stated she considered everything in the supply room to be harmful to the residents, especially the confused residents.</p> <p>Interview with the Administrator, on 10/22/15 at 3:04 PM, revealed the central supply room door locked automatically. The Central Supply Staff, Director of Nursing, Nurse Managers, and the Security Guard had keys to the central supply room. He further stated there were sharps stored in the room that could be harmful to residents.</p>	F 323		



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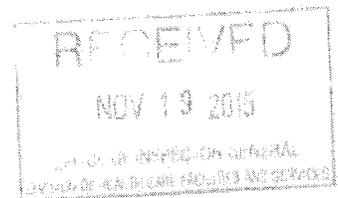
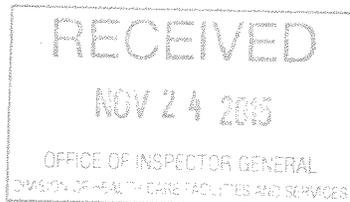
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F 323	<p>Continued From page 23</p> <p>Interview with the Director of Nursing, on 10/22/15 at 3:15 PM, revealed the central supply room door locked automatically and was never kept unlocked. She stated her, the central supply staff, and the supervisor's key ring had a key to the supply room. She stated there were sharps stored in the room that could be harmful to the residents.</p> <p>Observation, on 10/19/15 at 3:45 PM, revealed the utility closet on the 200 Hallway (2B) was unlocked and its contents were accessible to the residents. The closet door had a sign posted on it that read, "biohazard." The contents within the closet included: one bottle of multi-surface cleaner, two (2) cans of aerosol furniture polish, one bottle of glass cleaner with the top off; one bottle of hand-sanitizer, one bottle of liquid soap (half full with the top off), and jugs of solutions were stored on the floor that were connected to hoses. The hoses led to a spigot/faucet affixed to the interior closet wall.</p> <p>Interview, on 10/22/15 at 8:20 AM, with Housekeeper #5 assigned to 100 Hallway (1B) revealed while on duty, she kept a key to the utility closet. When not in use, the closet was to be kept locked to prevent residents or visitors from having access to the stored chemicals and cleaners. Housekeeper #5 stated the facility's managers also had keys to the utility closets. Housekeeper #5 stated on occasion she had discovered the 100 Hallway (1B) utility closet unlocked.</p> <p>Interview, on 10/22/15 at 8:40 AM, with Housekeeper #4 revealed the facility's policy was</p>	F 323			



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F 323	<p>Continued From page 24</p> <p>to keep the contents of the utility closets secured by keeping the door locked when not attended by staff. Housekeeper #4 stated the closets were to remain locked to prevent residents or visitors from having access to the stored chemical cleaning solutions. Housekeeper #4 stated the containers of cleaning solutions attached to the hoses and wall spigot included toilet cleanser, a liquid disinfectant for cleaning table tops and other surfaces, an air freshener, and a glass cleaning solution.</p> <p>Observation, on 10/22/15 at 8:40 AM, on the Transitional Rehab to Home Hallway (TRH) revealed Housekeeper #4 demonstrated how the spigot on the wall could be turned on by hand, similar to a sink's faucet handle, and the selected cleaning solution flowed from the wall spigot. Continued interview revealed housekeepers, floor technicians (staff that mopped the facility's floors), and the Housekeeping Supervisor had keys to the utility closets. In addition, Housekeeper #4 stated an additional key was kept at the receptionist's desk.</p> <p>Interview, on 10/22/15 at 9:45 AM, with Floor Technician #8 revealed while on duty, he kept a key to the facility's utility closets, as he periodically changed the mop water or obtained cleaning supplies. Floor Technician #8 stated the housekeeper's cleaning carts were stored in the utility closets when not in use, and he was responsible for restocking the carts when stored. Floor Technician #8 stated the utility closets were to remain locked when not attended by staff to prevent residents from having access to the closets' contents. Floor Technician #8 stated</p>	F 323			



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F 323	Continued From page 25 residents could drink or otherwise come in contact with the cleaning solutions and other potentially hazardous cleaning products if the closet was unlocked. Interview, on 10/22/15 at 9:05 AM, with the Housekeeping Supervisor revealed newly hired staff were instructed to ensure the utility closets were locked after they obtained any necessary supplies. He stated staff were instructed to lock the closets to prevent confused residents from accessing the closets' contents. The Housekeeping supervisor stated confused residents could drink the solutions, and/or get the cleaning solutions on their skin or in their eyes. The Housekeeping Supervisor stated the facility recently hired two (2) new housekeepers, and he thought one of them had been assigned to the 200 Hallway (2B) on 10/19/15 when the utility closet was discovered unlocked. In addition, the Housekeeping Supervisor stated the other new housekeeper was assigned to the TRH Hallway, and was working with Housekeeper #4 on 10/21/15. However, the Housekeeping Supervisor stated Housekeeper #4 was temporarily pulled to duties in the Laundry Department, which left the housekeeping orientee on the TRH Hallway, and not under the direct supervision of Housekeeper #4. Interview, on 10/22/15 at 3:00 PM, with the Facility Administrator revealed the Housekeeping Supervisor and all Housekeeping staff was responsible for making sure the utility closets remained locked when not in use. The Administrator stated if the closets were unlocked, residents could access the cleaning solutions.	F 323		

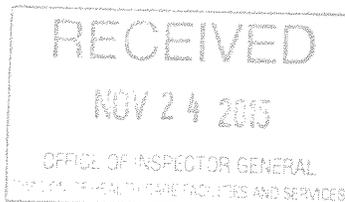
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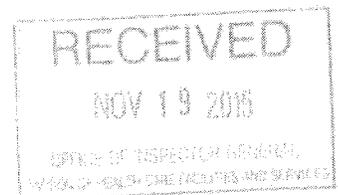
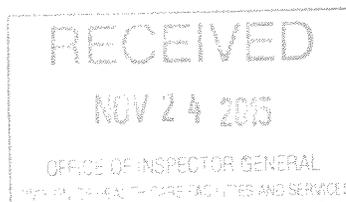
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F 323	Continued From page 26 stored in the closets. The Administrator stated that he, the Housekeeping Supervisor, the Housekeeping Staff, the Maintenance Director, and the Security Guard at the Receptionist's Desk had access to keys to the closets.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 1. Resident #11 abdominal wound had no negative outcome from the dressing change on 10/21/15. The wound continued to progress and the resident discharged on 10/23/15. 2. The facility completed an observation of all residents with wounds finishing on 11/13/15 by the wound nurse. None were found to be infected related to dressing changes.	12/5/15	



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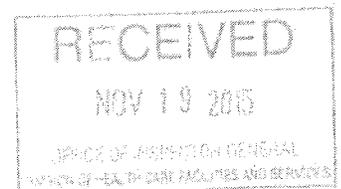
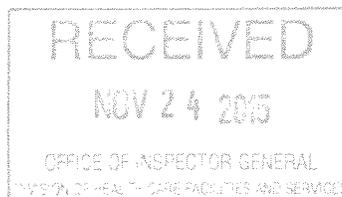
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203	
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F 441	<p>Continued From page 27</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to maintain effective infection control practices for one (1) of twenty-three (23) sampled residents, (Resident #11). LPN #1 failed to wash their hands during wound care when going from a dirty task to a clean task.</p> <p>The findings include:</p> <p>Review of the Hand Washing Policy, not dated, revealed the staff would wash their hands as necessary to prevent the spread of infections or germs.</p> <p>Review of Resident #11's Clinical Record, revealed Resident #11 was admitted on 09/29/15 with a diagnosis of Acute Vascular Insufficiency and Rehab</p> <p>Observation of Licensed Practical Nurse (LPN) #1 (Agency Nurse) providing wound care to Resident #11, on 10/21/15 at 10:05 AM, revealed LPN #1 washed his hands and donned new gloves at the beginning of the procedure. He removed the old abdominal dressing from Resident #11's abdominal incision and observed the old abdominal dressing to have yellow and</p>	F 441	<p>3. All Licensed Nurses will be in-serviced on the P&P for dressing changes and Standard Precautions by 12/2/15. The Infection Control Nurse was in-serviced on 11/13/15 by the Director of Nursing to audit to observe a dressing change, donning and doffing gloves, and washing hands 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then as recommended by the QAPI Committee</p> <p>4. The results of the audits will be reported to the QAPI monthly for four consecutive months, then as recommended by the QAPI Committee.</p>	



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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203	
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F 441	<p>Continued From page 28</p> <p>brown drainage. LPN #1 then removed his gloves, donned new gloves without washing or sanitizing his hands. Took a 4 x 4 pad with Normal Saline and cleaned Resident #11's wound. Removed his gloves and donned new gloves without washing his hands and applied a new abdominal dressing to Resident #11's surgical incision.</p> <p>Interview with LPN #1, on 10/21/15 at 10:20 AM, revealed he knew to remove his gloves and wash his hands when going from dirty to clean when providing wound care. LPN #1 stated if you do not wash your hands when moving from dirty to clean you could potentially transfer germs and bacteria that was on your arms or other potential places that he was not aware was touched and cause the resident to obtain an infection.</p> <p>Interview with the Rehab Unit Manager, on 10/22/15 at 1:54 PM, revealed the facility did not provide any wound care training to agency staff. She stated when a staff member removed an old dressing that this part of the procedure was known to be dirty and she would expect the staff member to wash their hands to prevent the spread of germs into the clean wound. The Rehab Unit Manager stated the staff member should have completed hand hygiene, removed the dirty dressing, removed gloves and washed his hands and then applied the clean dressing.</p> <p>Interview with the Wound Nurse, on 10/22/15 at 1:40 PM, revealed she monitored the wounds and worked with the wound care center to monitor the treatments and progress of each resident. The Wound Nurse stated that the nursing staff completed the actual wound care. She expected the nursing staff to follow infection control</p>	F 441	<p><u>Addendum</u> F441 11/19/15 (MD)</p> <p>#3 The Infection Control Nurse was in-serviced on 11/13/15 by the Director of Nursing to audit to observe a dressing change, donning and doffing gloves, and washing hands 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 2 times weekly for 2 months, then weekly for 2 months, then as recommended by the QAPI Committee.</p> <p>#4 The results of the audits will be reported to the QAPI monthly for six consecutive months, then as recommended by the QAPI Committee.</p>	12/5/15



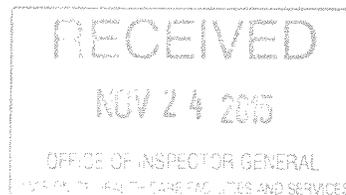
Addendum - 11/23

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F441

COMPLETION DATE
12/5/15

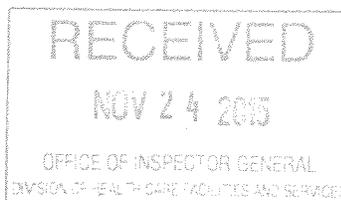
#4. The results of the audits will be reported by Director of Nursing to the monthly QAPI committee meeting.



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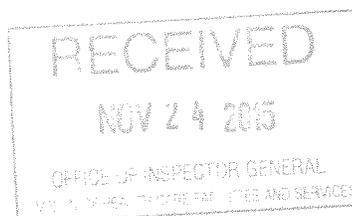
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F 441	Continued From page 29 practices and to wash their hands when moving from dirty to clean.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to ensure accurate documentation of treatment records for three (3) of twenty-three (23) sampled	F 514 F514	1. Resident # 5 - physician orders were audited by for skin care interventions by the Director of Clinical Support on 11/12/15. His documentation was reviewed, and an observation of the resident was made to verify and determine the accuracy of the nurse's documentation on 11/13/15 by a nurse manager..	12/5/15



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F 514	Continued From page 30 residents, (Resident #4, #5 and #11). The findings include: Review of the Clinical Record Policy, not dated, revealed the electronic clinical record would be maintained in an accurate and complete format. 1. Review of the Clinical Record for Resident #5, revealed the facility admitted the resident on 10/15/15 with diagnoses of Pressure and Vascular Wounds. Review of Resident #5's, Physician Orders, dated 10/17/15, revealed Resident #5's heels were to be elevated and kept off of the resident's bed. Observation of Resident #5, on 10/20/15 at 2:38 PM and 3:28 PM, on 10/21/15 at 8:30 AM and 10:25 AM, and on 10/22/15 at 9:12 AM, revealed Resident #5 was lying down on his/her bed with feet not elevated and lying on the mattress. Review of Resident #5's Treatment Administration Record (TAR) for the days of 10/20/15 and 10/21/15, revealed the nursing staff documented Resident #5's heels were elevated and kept off the bed. Interview with Licensed Practical Nurse (LPN) #5, on 10/22/15 at 12:20 PM, revealed the nursing staff documented in the electronic record that Resident #5's feet were elevated and off of the bed. LPN #5 stated the record would not be accurate if the nurses documented the task was done and it was observed not to be done. She stated the nurses should verify that the task was completed before documenting the task had been done.	F 514	2. An audit was completed by the Director of Clinical Support on 11/12/15 to identify all residents who have an order for skin care interventions including to elevate feet off of the bed and for Ted Hose application. For those residents found to have orders, the documentation will be reviewed, and an observation of the resident will be made to verify and determine the accuracy of the nurse's documentation on 11/13/15 by a nurse manager.	



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F 514	Continued From page 31 Interview with the Rehab Unit Manager, on 10/22/15 at 1:54 PM, revealed when there was an order for a treatment the nurse was to make sure the treatment was done, even if it meant for the nurse to make an observation to verify the treatment was done. The Rehab Unit Manager stated she did not want the nurses to document falsely. If the documentation was documented falsely it would cause the Clinical record to be inaccurate. Interview with the Director of Nursing (DON), on 10/22/15 at 2:10 PM, revealed when doing treatments it was just like administering medications, the nurse must go and see that the treatment was being provided and then document the treatment was completed. The DON stated if the treatment was not done and the nurse documented that it was, this would cause the resident to not have an accurate record. 2. Review of the clinical record for Resident #18, revealed the facility admitted the resident on 04/22/14 with diagnoses of Essential Hypertension, Type 2 Diabetes, Chronic Pain, Vitamin B-12 Deficiency Anemia, a History of Pulmonary Embolus, Unspecified Atrial Fibrillation (Arrythmia), Congestive Heart Failure, and Insomnia. Review of Resident #18's physician's orders revealed an order, dated 11/04/14 and ongoing, for the application of knee-high Thrombo-Embolic Deterrent (TED) hose to be placed on the resident's legs in the morning (AM), and they were to be removed at bedtime.	F 514	3. An In-service with Licensed Nurses will be completed on the P&P for Documentation by 12/2/15 The Nurse Managers were in-serviced on 11/13/15 audit comparing the Treatment Administration Record documentation and resident observation to assure treatment was completed as ordered 10 times weekly for 4 weeks, then 5 times weekly for 4 weeks, then weekly for 2 months. 4. The results of the audits will be reported to the Quality Assurance Committee monthly for 4 consecutive months.	

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Addendum – 11/23

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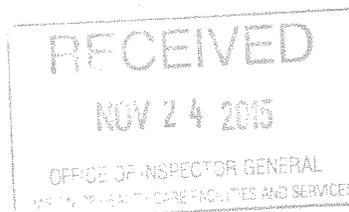
F514

COMPLETION DATE
12/5/15

#3. The Director of Nursing provided the education on 11-13-2015 to unit managers. The Director of Nursing will provide the education to licensed nurse staff on 12-2-2015.

An audit comparing the Treatment Administration Record documentation and resident observation to assure treatment was completed as ordered 10 times weekly for 4 weeks, then 5 times weekly for 4 weeks, then weekly for 4 months.

#4. The results of the audits will be reported by the Director of Nursing to the Quality Assurance Committee monthly for 6 consecutive months.



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F 514	Continued From page 32 Observation, on 10/22/15 at 10:55 AM, revealed Resident #18 seated in his/her room, in a wheelchair and dressed in street clothes, with slip-on moccasin style shoes on his/her feet. Resident #18's legs were visible from the knees down, and he/she was not wearing TED hose. Further observation at 11:25 AM, revealed Resident #18 was seated in his/her room in a wheelchair, talking with a visitor. Resident #18 continued to wear the moccasin style shoes, but again he/she was not wearing TED hose. Additional observation revealed two (2) knee-length TED hose draped over the back of a straight chair near Resident #18's bed. Interview, on 10/22/15 at 11:05 AM with Certified Nursing Assistant (CNA) #1, revealed she was assigned to provide Resident #18's daily care, and that the resident did not require TED hose. Review, of the 100 Hallway CNA assignment sheet (not dated), revealed the application of TED hose was not listed as a care intervention for Resident #18. Interview, on 10/22/15 at 11:20 AM with Licensed Practical Nurse (LPN) #1, revealed he was assigned to the 100 Hallway to administer the residents' medications. LPN #1 stated he was an agency nurse and that since he had not worked very long on the 100 hallway, the Unit Manager (UM) had been helping him out with the residents' treatments and assistive devices.	F 514		

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F 514	Continued From page 33 Review of Resident #18 Treatment Administration Record (TAR), dated 10/22/15, revealed that on 10/22/15 at 7:40 AM, LPN #1 documented the TED hose as having been "administered," (placed); however, observations on 10/22/15 at 10:55 AM and 11:25 AM, revealed Resident #18 was not wearing his/her TED hose while seated in his/her wheelchair. Continued interview, on 10/22/15 at 2:10 PM, with LPN #1 revealed he had gone into Resident #18's room to perform his/her morning accu-check (blood glucose test), but the resident was in bed and his/her TED hose had not yet been applied. LPN #1 stated he documented the TED hose as applied at 7:40 AM when he returned to the medication cart. LPN #1 stated he should not have documented the application of the TED hose until he had checked to be sure they had been placed on Resident #18 as ordered. LPN #1 stated licensed nurses should not sign off on a treatment or care application before it had been administered or completed. Interview, on 10/22/15 at 2:15 PM, with the 100 Hallway Unit Manager (UM), revealed the nurse who signed off on the TAR was responsible for ensuring the treatment had been administered/applied before documenting the treatment as completed. 3. Review of Resident #4's clinical record revealed the facility admitted the resident on 01/27/15, with diagnoses of Hypertension, Epilepsy, Anemia, Dementia Without Behaviors, Major Depressive Disorder, Allergy Unspecified,	F 514		

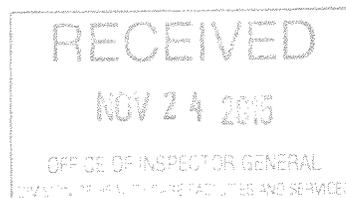
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F 514	<p>Continued From page 34 and Myoclonus.</p> <p>Review of a verbal Treatment Order, electronically signed 05/26/15, by Resident #4's physician revealed the staff was to apply bilateral knee high TED Hose to the resident twice a day. The Treatment Order read the TED Hose were to be on in the mornings and off at bed time.</p> <p>Review of the October 2015 Treatment Administration Record (TAR) revealed staff nurses had documented that Resident #4's TED hose had been applied upon rising and removed at bedtime from 10/1/15 through 10/20/15 and had been applied in the morning of 10/21/15.</p> <p>Observation, on 10/20/15 at 1:11 PM, revealed Resident #4 was seated in his/her wheelchair in the television area on the 2nd Floor and he/she was eating lunch at the dining table. Observation also revealed Resident #4 had on non-skid socks, but no TED hose.</p> <p>Observation, on 10/20/15 at 3:05 PM, revealed Resident #4 was seated in his/her wheelchair watching television with two other residents in the television area on the 2nd Floor. Resident #4 continued without TED hose on underneath his/her non-skid socks.</p> <p>Observation, on 10/21/15 at 8:53 AM, revealed Resident #4 was self-propelling down the hallway into his/her bedroom dressed for the day in pants, shirt, and a sweater, without TED hose on underneath his/her non-skid socks.</p> <p>Interview with Certified Nurse Assistant (CNA) #2, on 10/21/15 at 9:40 AM, revealed had never placed TED hose on Resident #4 in the seven (7)</p>	F 514		



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F 514	<p>Continued From page 35 months she had been employed by the facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 10/21/15 at 4:16 PM, revealed the night shift CNA had placed TED hose on Resident #4 the morning of 10/21/15. LPN #3 stated she had visually verified that the TED hose were actually on the resident and she had documented that the TED hose were on, into Resident #4's electronic TAR. LPN #3 also stated that if a nurse documented a treatment had been done that wasn't done, the resident's medical record would not accurately reflect the resident's treatment.</p> <p>Interview with the 2B Nurse Manager, on 10/21/15 at 4:36 PM, revealed after she saw Resident #4 had returned from breakfast without his/her TED hose on as ordered, she had CNA #2 to assist her to put the TED hose on the resident. The 2B Nurse Manager also stated the nurse shouldn't have documented the administration of the TED hose in Resident #4's TAR unless she had actually seen the resident with them on. The 2B Nurse Manager further stated the documentation of Resident #4's TAR on 10/21/15 that stated the TED hose was applied was documented in error by the nurse.</p> <p>Interview with the Director of Nursing (DON), on 10/22/15 at 10:11 AM, revealed the physician's order to have TED hose applied to Resident #4 twice a day should have been followed through by nursing staff. The DON stated the nurse assigned to the hall should have verified that the TED hose were actually placed on the resident by the CNA, before it was documented as completed on the Treatment Administration Record (TAR). The DON also stated staff should adhere to the facility's policy regarding accurate and complete</p>	F 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 36 documentation in residents' clinical records. The DON further stated TED hose were applied to residents to prevent the accumulation of fluid in the patient's legs.	F 514			

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