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

PRINTED: 10/13/2010
FORM APPROVED
OMB NO. 0938-0391

RECEIVED OCT 2010 OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185318		09/29/2010

NAME OF PROVIDER OR SUPPLIER: CHRISTIAN CARE CENTER OF KUTTAWA, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE: 1253 LAKE BARKLEY DRIVE, KUTTAWA, KY 42055

(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 annual survey was conducted on 09/27/10 through 09/29/10 to determine compliance with Federal certification requirements. The facility was found not to meet Federal requirements for recertification with the highest S & S being a "D".	F 000	Disclaimer for Plan of Correction Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Kuttawa of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Kuttawa files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/ Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide services in accordance with professional standards of quality for one resident (#17), not in the selected sample. Resident #17's medication was not administered in accordance with physician's orders. Findings include: A record review revealed Resident #17 was admitted to the facility with diagnoses to include Chronic Heart Failure, Hypertension, Atherosclerotic Peripheral Vascular Disease, Cardiomyopathy, Chronic Kidney Disease, Deep Vein Thrombosis, Liver Disorder, and Left Ventricular Hypertrophy. A review of the quarterly Minimum Data Set, dated 07/29/10, revealed the facility identified Resident #17 with a cognitive status which required modification of independence. A review of the physician's orders and Medication Administration Record (MAR), dated September 2010, revealed the orders included (original order	F 281	F 281 Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Adm. (X6) DATE: 10/18/10

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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	185318		09/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF KUTTAWA, LLC	1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055

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F 281	Continued From page 1 08/12/19) Docusate Sodium (Colace) 250 mg, one capsule by mouth twice daily, scheduled for administration twice a day at 8:00 AM and 8:00 PM and (original order 03/10/10) Lactulose 10 GM/15 milliliters (ml) solution, 15 ml by mouth once daily, which was scheduled for administration at 8:00 AM. Review of the MAR revealed documentation reflected the medication was given at 8:00 AM on 09/27/10. An observation, on 09/27/10 at 9:55 AM, revealed medication was located in medication cups at the resident's bedside. One medication cup contained a red gel capsule, later identified as Colace and a medicine cup contained 15 cc of an orange liquid, later identified and Lactulose (laxative). An interview with Licensed Practical Nurse #1, on 09/27/10 at 10:50 AM, revealed he was responsible for medication administration on 09/27/10 (day shift). He stated, "I thought I saw the resident take the medication". He stated he was aware he should have ensured the resident consumed the ordered medications prior to leaving the room. A review of the facility's policy and procedure for "Medication Administration: Unit Cart Dose System", dated 11/88 and revised 09/08, revealed staff was to administer oral medication and observe the resident swallow the medication, also drugs were never to be left in the residents' rooms. An interview with the Director of Nursing, on 09/28/10 at 9:00 AM, revealed unless a resident had been assessed and identified as capable to self-administer medication, she expected staff to follow the facility policy and ensure residents	F 281	Corrective Actions for Targeted Residents Medication left at bedside was verified per MAR to belong to Resident #17. The medication was then given as ordered by the physician. Identification of Other Residents with Potential to be Affected Due to the nature of this practice, current residents in the facility could be affected. The Director of Nursing immediately met with the medication nurses on 9-27-10 to ensure that no other medications had been left at the bedside. Systematic Changes On 9-27-10, the LPN who left the medication at the bedside was counseled as to the importance of making sure the residents are observed taking medications prior to leaving the room. Licensed nurses will be educated on 10-14-10 and 10-15-10 regarding medications left at the bedside. The in-service to include that medications are to be given in completion prior to nurse leaving the resident's room. Monitoring Ten percent of medication passes will be audited by the Director of Nursing, Assistant Director of Nursing, and/or the consultant pharmacist monthly X3 months. Findings will be reported to the Performance Improvement Committee for review and	

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CHRISTIAN CARE CENTER OF KUTTAWA, LLC	1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055

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F 281	Continued From page 2 consumed their medications, prior to staff leaving the residents' rooms. Record review revealed Resident #17 was not assessed as capable of self-administration.	F 281	further recommendations. Said Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Housekeeping/ Laundry Director, Maintenance Director, Business Office Manager, Social Service Director, Dietary Manager, Activity Director, and MDS Coordinator.	10-18-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted on 09/28/10 to determine Federal compliance with Title 42, Code of Federal Regulations, 482.41 (b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency at an D.	K 000	Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure there were no obstructions to the full development of the sprinkler spray pattern in one of 30 resident rooms inspected. This condition affected two of 68 residents. Examples include: During the Life Safety Code inspection conducted on 09/28/10 at approximately 10:30 AM, the cubical curtain in Resident Room #226 was	K 056	Corrective Actions for Targeted Residents On 10-14-10, the Maintenance Director installed the cubicle privacy curtain with ½" mesh at the top of the curtain in Room 226. Identification of Other Residents with Potential to be Affected On 9-28-10, the Maintenance Director walked through the facility and identified Rooms 225, 228, and 229 as having cubicle curtains that needed to be replaced because the mesh size did not meet current requirements. The replacement of these cubicle curtains was completed on 10-14-10. Other curtains in the facility met the ½" requirement. Systematic Changes The Administrator will review any additional orders of cubicle curtains to ensure that they meet the current requirement of ½" mesh size at the top of the cubicle curtains.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Adm. — (X6) DATE 10/18/10

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	185318	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/28/2010

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K 056	Continued From page 1 observed to have eighteen inches of mesh at the top of the curtain which measured less than the required 1/2 inch, when measured on the diagonal. NFPA 13 Standard for Automatic Sprinkler Systems states: 5-6.5.3* Obstructions that Prevent Sprinkler Discharge from Reaching the Hazard. Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. (457 mm) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section. A-5-6.5.2.3 The distances given in Table 5-6.5.2.3 were determined through tests in which privacy curtains with either a solid fabric or close mesh [1/4 in. (6.4 mm)] top panel were installed. For broader-mesh top panels - for example, 1/2 in. (13 mm) or greater measured on the diagonal - the obstruction of the sprinkler spray is not likely to be severe and the authority having jurisdiction might not need to apply the requirements in 5-6.5.2.3. An interview with the Maintenance Director at 10:40 AM, on 09/28/10, revealed he was aware of the requirements for the 1/2 inch mesh at the top of the cubicle curtains, and that new curtains had been purchased but had not been installed yet.	K 056	Monitoring Beginning 9-28-10, the Maintenance Director walked throughout the entire facility to ensure it is in compliance. Findings will be reported on a monthly basis times three, and then on a quarterly basis to the Performance Improvement Committee, which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Housekeeping/Laundry Director, Maintenance Director, Business Office Manager, Social Service Director, Dietary Manager, Activity Director, and MDS Coordinator. The facility Administrator and Maintenance Director will follow up on Performance Improvement Committee recommendations to assure compliance.	10-14-10