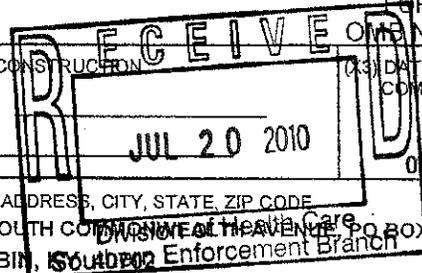


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Amended SOD

PRINTED: 07/02/2010  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/24/2010
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMERCE STREET, CORBIN, KY 40602 116 SOUTH COMMERCE STREET, CORBIN, KY 40602 CORBIN, KY 40602
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F 000	INITIAL COMMENTS	F 000	Preparation or execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required by the provision of federal and state law.	
F 156 SS=D	<p>*AMENDED</p> <p>A standard health survey was conducted on May 23-25, 2010. An extended survey was conducted on June 23-24, 2010. Deficient practice was identified with the highest scope and severity at "H" level, with no opportunity to correct. Substandard Quality of Care was identified at 483.25 Quality of Care (F323 Accidents) at a scope and severity of "H."</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)</p>	F 156	<ol style="list-style-type: none"> <li>1. Resident # 12 had been issued a denial letter. A copy of that notice could not be located. Therefore Resident # 12 was verbally informed of what occurred and was given a second denial letter for personal records. A copy was placed in the resident's financial folder.</li> <li>2. Between May 26 and June 9, 2010 the Business Office conducted an audit of in-house resident's financial/billing status. The Business Office audited records back to January 1, 2010. The Office assessed for residents who were admitted and/or re-admitted to the facility from the hospital, change in level of care, Medicare benefits being exhausted and change in payment status. Other residents had been notified appropriately and copies were in financial folders.</li> <li>3. The Administrator and Business Office staff reviewed/revised the procedure for denial letters on May 26, 2010. If the denial letter is not signed and returned the Business Office follows up with a telephone call and/or room visit with the resident and/or responsible party. This process is dated and witnessed on a copy of the denial letter.</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill Collins TITLE: Administrator (X6) DATE: 7-20-10

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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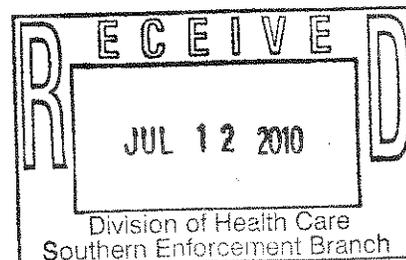
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NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702</b>		
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F 156	<p>Continued From page 1 (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p>	F 156	<p>4. The Business Office Staff will report any requests for demand billing and the progress of that demand bill at the Monday through Friday quality assurance meeting until the request for demand bill and denial letter are resolved. Copies of the denial notice will be placed in the resident's financial record. The Business Office Staff will keep a tracking log of denial letters and demand bills and present this to the quarterly quality assurance committee.</p>	6-30-2010	

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F 156	<p>Continued From page 2</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide evidence of a Notice of Medicare Provider Non-Coverage denial notice for one (1) of twenty-seven (27) sampled residents (resident #12).</p> <p>The findings include:  A review of one denial notice for non-Medicare coverage, since the preceding standard survey,</p>	F 156			



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F 156	Continued From page 3 revealed no evidence the facility sent a notice to the resident/responsible party.  An interview was conducted on May 25, 2010, at 7:45 p.m., with the Office Personnel (OP) responsible for issuing the notices. The OP stated the OP mailed the notice to the resident's responsible party; however, the OP was unable to locate a copy of the notice that had been sent to the resident's responsible party.	F 156			
F 174 SS=B	<b>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY</b>  The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure residents had reasonable access to the use of a telephone where calls could be made without being overheard for one (1) of twenty-seven (27) sampled residents (resident # 22). Resident #22 was observed to receive a telephone call at the nurses' station on May 25, 2010.  The findings include:  An observation of resident #22 on May 22, 2010, at 2:30 p.m., revealed the resident was at the nurses' station in a wheelchair with the telephone. Observation at the time revealed other conversations at the nurses' station with call bells sounding and family members talking around the resident.	F 174	<b>F 174 Right to Telephone Access</b>  1. Resident # 22 was not provided with privacy during that telephone conversation. Resident # 22 was instructed on how to access the telephone in private when desired.  2. All other residents who utilize the telephone could have been affected. An audit of residents who routinely utilize the telephone was conducted on May 27, 2010; no other residents were identified as not being provided with privacy as desired.  3. The policy and procedure for telephone use was reviewed and revised by the Administrator, Social Services Director (SSD) and Director of Nursing (DON). Upon admission to the facility resident and/or resident representative will be informed of telephone procedures to assure privacy if desired. A letter was sent to each resident and/or resident representative on June 10, 2010 by the Social Services Director to ensure that they were aware of telephone policy		

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F 174	Continued From page 4 An interview with resident #22 on May 25, 2010, at 2:45 p.m., revealed the residents on the third floor had to use the telephone at the nurses' station if the resident did not have their own phone. Resident #22 said that there was no privacy at the nurses' station, and it was hard to hear at the nurses' station.  An interview with the LPN charge nurse on the third floor on May 25, 2010, at 5:55 p.m., revealed there was no portable phone on the third floor. Residents were required to use the nurses' station telephone if a telephone call needed to be made or received.  An interview with the second floor charge nurse on May 25, 2010, at 6:00 p.m., revealed the residents usually utilized the telephone at the nurses' station; however, there was a portable telephone available for residents who could not come to the nurses' station. According to the LPN charge nurse, incoming calls could not be transferred to the portable telephone, and residents were required to utilize the nurses' station telephone.	F 174	(Continued from page 4) and procedure. All departments were re-educated by the Director of Nursing on May 26-27, 2010, June 1, 2010 and June 28-29, 2010 related to telephone availability and privacy as the resident desires.  4. The facility Social Service Director or designee will conduct a monthly audit, for the next 3 months, on a minimum of five (5) residents and five (5) staff members to ensure the residents and the staff know the policy and procedure for resident telephone privacy. The Social Service Director or designee will report audit findings monthly to the quality assurance committee for the next three (3) months. If problems are noted during this three (3) months the SSD/designee will continue the audits as stated for another three (3) months and report to the QA Committee monthly for the next (3) months. If no problems are noted in a three (3) month period the SSD will begin quarterly audits for the six (6) months to assure the problem does not recur and will report findings to the QA Committee Quarterly for six (6) months.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 248	F 248 Activities Meet Interest and Needs of Each Resident  1. The volume was turned up on Resident # 6's television by staff.	6/30/10

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F 248	<p>Continued From page 5</p> <p>provide an ongoing program of activities for the individualized assessed needs of one (1) of twenty-seven (27) sampled residents (resident #6). The facility had identified activities of interest for resident #6, however, failed to provide the identified activity for the resident.</p> <p>The findings include:</p> <p>Observations of resident #6 on May 23, 2010, at 12:15 p.m., 1:00 p.m., 4:30 p.m., 5:30 p.m., and 6:00 p.m., and on May 24, 2010, at 8:30 a.m., 9:00 a.m., 10:00 a.m., 10:30 a.m., 11:00 a.m., 1:00 p.m., 1:30 p.m., 2:30 p.m., 3:30 p.m., 4:30 p.m., and 5:00 p.m., revealed the television was turned on; however, no sound was coming from the television.</p> <p>A review of resident #6's Minimum Data Set (MDS) assessment dated March 28, 2010, revealed resident #6 was involved in activities from one-third to two-thirds of the time, and enjoyed television and music as in-room activities. Resident #6 had the following diagnoses: Diabetes, Organic Brain Syndrome, Osteoarthritis, Gastric Reflux Disease, Hypertension, Congestive Heart Failure, Aphasia, Renal Failure, and history of a Hip Fracture.</p> <p>Review of resident #6's care plan revealed altered thought processes related to dementia with severe cognitive loss. Interventions on the care plan included: care needs anticipated and provided by staff, and the resident's television turned on in the resident's room.</p> <p>An interview on May 25, 2010, at 9:30 a.m., with a Certified Nurse Aide (CNA) who worked on resident #6's hall revealed resident #6 did not get</p>	F 248	<p>(Continued from page 5)</p> <ol style="list-style-type: none"> <li>2. All other residents who are room bound had the potential to be affected. Between May 27, 2010 and June 10, 2010 an audit was conducted by the activity department of all room bound residents to assure the residents were being provided with assessed activities of interest. No other residents were identified.</li> <li>3. The activity assessment and care planning policy and procedure was reviewed/revised by the interdisciplinary care planning team. The DON re-educated employees May 26-27, June 1, June 28-29, 2010 related to the resident's activities of interest and the role each employee could play in assuring the resident's activity of interests were being provided on an ongoing basis.</li> <li>4. For the next three (3) months the Interdisciplinary Care Planning Team will audit 30 residents per month to assure assessed activities of interest are being provided ongoing for all residents. Findings from the audits will be reported to the QA Committee monthly for the next three (3) months. If problems are noted the audits will continue for another three (3) months as stated and reported monthly to the QA Committee. If the Interdisciplinary Care Planning Team finds no problems in a three (3) month period of time the audits will continue. The team will audit 30 residents per quarter for six (6)</li> </ol>		

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F 248	Continued From page 6 out of bed often related to the resident's poor posture and weakness with sitting upright. The CNA stated resident #6 was unable to communicate and utilized the television for activities. The CNA stated resident #6's roommate would turn off the sound on both the roommate's and resident #6's televisions. According to the CNA, resident #6's roommate kept the television on without sound all the time. The CNA stated when the television's sound was down the CNAs would turn it back up; however, the roommate would just turn it down again. Observation at the time revealed the CNA left the resident's room without turning the television sound back up.  An interview with the RN charge nurse for the third floor on May 25, 2010, at 11:00 a.m., revealed resident #6's television was to be on and the sound turned up. The RN charge nurse reported resident #6's roommate turned the television sound off routinely. The RN further stated Nursing and Activities staff was responsible for monitoring the resident's TV.  An interview with the Activities Coordinator (AC) on May 25, 2010, at 9:40 a.m., revealed resident #6 was unable to come out of the room for activities, and required 1:1 visits with the activity staff. According to the AC, resident #6 enjoyed television as the main leisure activity. The AC stated the resident's family visited the resident often and provided activities of talking to the resident about current events, music, and television. The AC was unaware resident #6's television sound had been turned down and stated it should be turned up so the resident could hear the television.	F 248	(Continued from page 6) months and the findings will be reported to the QA Committee quarterly.	6/30/10	
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279			

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F 279 SS=D	<p>Continued From page 7</p> <p><b>COMPREHENSIVE CARE PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop a comprehensive care plan to meet the nutritional needs for one (1) of twenty-seven (27) sampled residents (resident #5). Resident #5 was assessed to have sustained a significant weight loss. According to the Registered Dietitian (RD), the weight loss was desirable for the resident. However, there was no evidence the facility had developed a care plan to address the planned weight loss with measurable goals and interventions/education for safe weight loss for resident #5.</p>	F 279	<p>F 279 Develop Comprehensive Care Plans</p> <ol style="list-style-type: none"> <li>1. Resident # 5's care plan was reviewed and revised to reflect measurable goals/timetables on June 3, 2010. The dietitian met with resident # 5 on June 1, 2010 to discuss gradual weight loss. A significant change in status assessment was completed by the interdisciplinary assessment and care planning team on June 3, 2010.</li> <li>2. All current residents had the potential to be affected. Between May 28, 2010 and June 12, 2010 the Assessment Nurses reviewed and revised all current residents' care plans to assure goals and timetables were measurable.</li> <li>3. The comprehensive assessment and care planning policy and procedure was reviewed and revised by the interdisciplinary team. The DON re-educated staff on measurable goals/timetables on May 26-27, 2010, June 1, 2010 and June 28-29, 2010.</li> <li>4. For the next six (6) months the Director of Nursing or designee will audit ten (10) resident care plans each month to assure measurable goals and timetables are being defined for residents. The DON or designee will forward audit results to the QA Committee monthly for the next six (6) months. If problems are noted the audits will continue and findings will be reported to the QA Committee for an additional six (6) months. If no</li> </ol>		

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F 279	<p>Continued From page 8</p> <p>The findings include:</p> <p>Resident #5 was admitted to the facility on May 1, 2009, with diagnoses to include Degenerative Joint Disease, Depression, Chronic Ischemic Heart Disease, Anemia, Hyperlipidemia, History of Bilateral Hip Replacements, and Bilateral Total Knee Replacements.</p> <p>Resident #5 was observed on May 23, 2010, at 12:50 p.m., during the noon meal service. The resident was observed to receive a regular diet consisting of fried chicken, creamed potatoes, corn, tossed salad, fried apples, a biscuit, and buttermilk. Resident #5 was observed to consume less than 50 percent of the meal. On May 24, 2010, at 11:00 a.m., resident #5 was observed to be ambulating with the assistance of a walker and one staff member. Resident #5 expressed the desire to lose weight since the weight loss would aid the resident to improve ambulation after having bilateral total knee replacements.</p> <p>A review of the admission Minimum Data Set (MDS) assessment dated May 14, 2009, revealed resident #5's weight was 202 pounds and no weight loss/gain was identified. A review of the quarterly assessment dated December 31, 2009, revealed the resident weighed 164 pounds and was assessed to have sustained a weight loss during the assessment reference period. The quarterly assessment dated February 5, 2010, identified resident #5 to weigh 175 pounds with weight loss and gain noted. The annual MDS assessment dated May 4, 2010, identified resident #5 to weigh 170 pounds with weight loss indicated.</p>	F 279	(Continued from page 8) problems are identified in a six (6) month time period the DON or designee will audit 10 resident care plans per quarter and will report findings to QA Committee on a quarterly basis for an additional six (6) months.	7/4/10	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/24/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702</b>		
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F 279	<p>Continued From page 9</p> <p>A review of the Resident Assessment Protocol Summary (RAPS) dated May 4, 2010, revealed resident #5 was at 115 percent of the resident's Ideal Body Weight (IBW), and the resident was assessed to have sustained a 6.3 percent weight loss in one month, a 4.5 percent gain in three months, and a 3 percent loss in six months.</p> <p>A review of the comprehensive care plan revealed the facility assessed resident #5's weight loss on January 14, 2010, and noted the weight loss was "desired." On April 27, 2010, the facility noted on the resident's care plan that the resident's weight was 170.9 pounds, the resident was trying to lose weight, and the weight loss was desired by the resident, the resident's family, and the resident's physician. However, there was no evidence the facility had developed a plan of care to address the resident's desired weight loss with measurable goals and interventions to educate the resident regarding a safe, effective weight loss program.</p> <p>A review of the RD assessment dated May 3, 2010, revealed the resident was at high nutritional risk due to elevated Basic Metabolic Index (BMI) with weight loss, multiple medications, and abnormal labs. The RD noted the resident's albumin level was 3.0 (normal range 3.0 to 3.4 g/dL) and the total protein level was 5.8 (normal range 7.2 to 8.0 g/100 ml). The RD further noted resident #5 did not want to gain weight and refused any nutritional supplements.</p> <p>An interview conducted with the RD on May 24, 2010, at 2:10 p.m., revealed resident #5 was currently receiving a regular diet and consuming approximately 50 percent of the meals served.</p>	F 279			

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F 279	Continued From page 10 The RD stated the RD did not attend the care plan conferences and no weight loss goal had been established for resident #5.  An interview with the Dietary Manager (DM) on May 24, 2010, at 2:40 p.m., revealed the DM had discussed food preferences with resident #5; however, the DM had not discussed weight goals/interventions with the resident. The DM stated the MDS nurse was responsible for the development of the care plan for the residents. The DM attended the care plan meetings; however, the weight loss, goals, and diet plan had not been reviewed/discussed for resident #5.  An interview conducted with the MDS nurse on May 24, 2010, at 3:00 p.m., revealed residents identified with weight loss were reviewed during the Nutritional at Risk Meeting (NAR) conducted twice a month. The MDS nurse stated resident #5's weight loss had been discussed during the NAR meeting, however, was unable to provide any evidence of the NAR meeting concerning resident #5. The MDS nurse stated a desired weight loss goal should have been determined/implemented for the resident and included in the resident's plan of care.	F 279			
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 observations, interview, and record review, it was determined the facility failed to meet professional standards of practice for four	F 281	F 281 Professional Standards  1. (a). Resident # 27's medication, Carbidopa-Levodopa ER 25/100 mg was crushed by mistake and RN # 1 realized the medication should not have been crushed. Resident # 27's Carbidopa-Levodopa medication is not being crushed. (b). Resident # 15 received the correct medication. (c). Resident's # 2 and # 4 were given ice cream at the lunch and dinner meals.		

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F 281	<p>Continued From page 11</p> <p>(4) of twenty-seven (27) sampled residents (residents #2, #4, #15, and #27). The facility staff failed to follow standards of practice during the medication administration for residents #27 and #15. In addition, the facility failed to follow physician's orders for two (2) residents. Residents #2 and #4 had physician's orders for ice cream to be served at the lunch and dinner meals; however, ice cream was not served to these residents.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>During the medication administration observation on May 24, 2010, at 1:56 p.m., observation of Registered Nurse (RN) #1 revealed Carbidopa-Levodopa ER 25/100 mg was administered to resident #27 crushed in applesauce. Record review of the Physician's Order Form dated May 2010 revealed the physician's order was written as Carbidopa-Levodopa ER 25/100 mg "Do Not Crush."</li> <li>During the medication administration observation on May 24, 2010, at 4:00 p.m.,</li> </ol> <p>An interview conducted with RN #1 on May 24, 2010, at 2:15 p.m., revealed the RN was aware the medication was an extended release medication and should not be crushed. RN #1 stated she was aware of the notation on the resident's Medication Administration Record (MAR) of "Do Not Crush" directions for administering the medication. RN #1 further stated she was usually assigned to work on another floor and just overlooked the directions provided on the Medication Administration Record (MAR).</p>	F 281	<p>(Continued from page 11)</p> <ol style="list-style-type: none"> <li>(a) Other residents in the facility with instructions to not crush medications could have been affected. Licensed Nurses reviewed each resident's medication administration records to assess for any needed medication changes and if necessary notified the resident's Physician to clarify medication orders and instructions on medication administration. (b) Availability of medications for other residents was assessed and the residents did have prescribed medications available for administration. (c). To assure no other residents were affected, the dietary manager compared each resident's prescribed diet to the resident's tray cards to assure the correct physician's orders was on the resident's tray card. No other residents were identified.</li> <li>(a). (b). The Director of Nursing re-educated the nursing staff on May 26-27, 2010, and June 1, 28-29, 2010 related to following physician's orders for medication administration. The DON emphasized that medications are not to be borrowed, how to obtain prescribed medications and that if the resident could not consume medications as prescribed the resident's physician was to be notified and informed of the resident's inability to take prescribed medications. (c). On May 26-27, 2010, and June 1, 28-29, 2010 the DON re-educated the</li> </ol>		

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F 281	<p>Continued From page 12</p> <p>resident #15 did not have any Simethicone 80 mg in the resident's drawer. The certified medication aide (CMA) went to the Licensed Practical Nurse (LPN) charge nurse to report the missing medication. The LPN charge nurse checked the medication emergency box, which did not have the required medication. The LPN charge nurse then took the Simethicone from another resident's medication drawer, and told the CMA to administer the medication to resident #15. The CMA administered 80 mg of Simethicone to resident #15.</p> <p>An interview with the CMA on May 24, 2010, at 4:45 p.m., revealed the CMA was to report any missing medication to the nurse in charge, who would obtain the medication for the CMA from the emergency medication box. The CMA stated if a medication was unavailable the facility policy was to initial the Medication Administration Record (MAR) and circle the initial indicating the medicine was not given and write on the back of the MAR the reason for not giving the medication.</p> <p>An interview with the LPN on the third floor on May 24, 2010, at 4:30 p.m., revealed the facility policy for missing medication was to initial the MAR, circle the initial, and write on the back of the MAR the reason for not giving the medication. The LPN was then to order the medication from the pharmacy. The LPN was aware of the facility's policy prohibiting borrowing medications from other residents.</p> <p>An interview with the Unit Manager from the third floor on May 24, 2010, at 4:30 p.m., revealed the pharmacy should be contacted when a medication was unavailable in the medication cart or the emergency medication box. The Unit</p>	F 281	<p>(Continued from page 12)</p> <p>nursing staff and the dietary staff on the importance of providing each resident with the diet as prescribed by the resident's physician. The DON instructed the staff that each resident's tray card was to be read at the point of service to assure each item on the card was delivered as instructed on the tray card and prescribed by the resident's physician. On June 1, 2010 and June 8, 2010 the Registered Dietitian re-educated the dietary staff on the importance of providing diets as ordered by the resident's physician.</p> <p>4. (a). (b). For the next 12 months the DON, ADON and Unit Managers will conduct monthly audits at various medication administration times to assure medications are not being crushed or borrowed and that medications are being administered as prescribed by the resident's physician. The results of the audits will be presented to the QA Committee monthly for the next 12 months. (c). For the next six (6) months the Registered Dietitian and/or the Dietary Manager will conduct monthly audits to assure that resident's are receiving diets as prescribed by each resident's physician. The results of the audits will be presented monthly to the QA Committee for the next six (6) months.</p>	6/30/10	

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F 281	<p>Continued From page 13</p> <p>Manager stated the facility's policy prohibits staff from borrowing medications from another resident.</p> <p>3. A review of the physician's orders dated June 2, 2009, for resident #2 revealed an order for a regular pureed diet without seeds or hulls and ice cream at lunch and supper.</p> <p>Observation of resident #2's tray at 4:55 p.m. on May 23, 2010, revealed LPN #4 was feeding resident #2 dinner. No ice cream was included on the resident's tray.</p> <p>An interview with LPN #4 conducted at 4:55 p.m. on May 23, 2010, revealed the LPN was aware the resident was supposed to receive ice cream, but had assumed the Dietary Department had sent fruit as a substitute.</p> <p>4. A review of the physician's orders for resident #4 revealed the resident's physician had ordered a regular no-added-salt diet with chopped meat and ice cream at lunch and supper.</p> <p>Observation of resident #4's meal trays at 1:00 p.m. on May 23, 2010, at 5:55 p.m. on May 23, 2010, and at 1:15 p.m. on May 24, 2010, revealed no ice cream was served to resident #4 as ordered.</p> <p>An interview with the Unit Manager (UM) conducted at 5:55 p.m. on May 23, 2010, revealed the staff who served the meal was responsible for checking to ensure likes/dislikes were honored and that all food items on the tray were correct. The UM further stated he had served resident #4's tray at 5:55 p.m. on May 23, 2010, and failed to check the tray card for</p>	F 281		
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F 281	Continued From page 14 accuracy.  An interview with LPN #5 conducted on May 24, 2010 at 1:15 p.m., revealed the staff on the floor was responsible to add ice cream to residents' trays as ice was kept on the unit at all times to ensure it was served at the appropriate temperature. LPN #5 further stated the staff serving meal trays was responsible for reading the tray cards to ensure accuracy and that no other staff was responsible to monitor tray accuracy.	F 281			
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PYSCHOSOCIAL DIFFICULTIES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one (1) of twenty-seven (27) sampled residents (resident #5) received appropriate treatment and services for symptoms of depression, psychosocial adjustment to the death of the resident's spouse and son, and admission to the facility. Resident #5 was readmitted to the facility with a history of severe depression and passive suicidal ideation due to the loss of the resident's spouse and son. However, there was no evidence the facility provided care and services to assist the resident to reach and maintain the highest level of mental and psychosocial functioning.	F 319	F 319 Mental and Psychosocial Difficulties  1. The Social Services Director met with Resident # 5 on May 25-26, 2010, June 8, 2010 and June 14, 2010 to assess and discuss mood symptoms. On May 24, 2010 Resident # 5's Celexa was increased to 30 milligrams per day; on May 24, 2010 the medication was discontinued due to paranoid statements. Physician re-ordered . Celexa at 20 milligrams per day on June 3, 2010. On June 3, 2010 a comprehensive significant change assessment was conducted by the interdisciplinary assessment and care planning team. Physician assessed resident on June 6, 2010 and gave order to continue the Celexa and to add Wellbutrin 100 milligrams daily.  2. All current residents had the potential to be affected. The DON and Social Service Director reviewed in house residents' mood and behavior documentation for May 1, 2010 through		

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F 319	<p>Continued From page 15</p> <p>The findings include:</p> <p>A review of the medical record revealed resident #5 was admitted to the facility on November 6, 2009, with diagnoses to include Anxiety State and Depressive Disorder. A review of the admission physician's orders revealed the resident had a physician's order for Wellbutrin SR 100 milligrams (mg) to be administered routinely once a day and Xanax 0.5 mg to be administered three times a day.</p> <p>Further medical record review revealed resident #5 was admitted to the hospital on January 18, 2010, related to an infection of the right knee following a total knee replacement. A review of the psychiatric consultation revealed resident #5 complained of severe depression, expressed thoughts of passive suicidal ideation, and a psychiatric consultation was conducted on January 25, 2010.</p> <p>Further review of the psychiatric evaluation conducted on January 25, 2010, revealed resident #5 reported problems of depression after the death of the resident's son six years ago. Resident #5 stated the depression had become worse after the resident's spouse expired three years ago, and after the resident was placed in the nursing home. The evaluation noted the resident felt betrayed by the resident's children when placed in the nursing home. The evaluation noted resident #5 had never had a suicide attempt and would "never truly kill herself" because of the resident's religious beliefs. The evaluation further noted the Wellbutrin had recently been discontinued and Lexapro 20 mg was currently being administered daily, in addition to Restoril 15 mg in the evening. The evaluation</p>	F 319	<p>(Continued from page 15)</p> <p>May 31, 2010 for unmet mental and psychosocial symptoms. Care plans were reviewed and revised as indicated.</p> <p>3. The interdisciplinary care planning team reviewed/revise the mood and psychosocial assessment and care planning process related to assessment, treatment and services for mental and psychosocial difficulties. On May 26-27, 2010, June 1, 2010 and June 28-29, 2010 the DON re-educated staff on the role each employee had on reporting signs and symptoms of unmet mental and psychosocial needs. The staff was re-educated on the importance of reporting and documenting mood and behavior symptoms for each resident. The mood and behavior logs will be printed by the 5<sup>th</sup> of each month for the preceding month and will be reviewed by the Social Service Director by the 10<sup>th</sup> of each month to assure mood and behavior symptoms are assessed and treated appropriately.</p> <p>4. The Director of Nursing or designee will audit mood and behavior logs of 30 residents each month for the next six (6) months to assure that residents' mental and psychosocial issues are being assessed and treated appropriately. The results of audits will be forwarded to the QA Committee monthly for the next six (6) months.</p>	6/30/10

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F 319	<p>Continued From page 16</p> <p>noted resident #5 would benefit from further psychiatric treatment and stated the resident was adamant about not going to the psychiatric unit. The evaluation indicated the resident was encouraged to tell the nursing staff if any thoughts of suicide occurred. The evaluation further noted resident #5 would be followed in the clinic for further psychiatric intervention and Wellbutrin would possibly need to be resumed.</p> <p>Resident #5 was observed on May 23, 2010, at 12:35 p.m. and at 3:55 p.m., to be sitting in a recliner chair in the resident's room. A photo was on the wall beside the resident's chair and on the wall facing the resident's chair. Resident #5 stated the photos were of her deceased son and spouse.</p> <p>During an interview conducted with resident #5 on May 24, 2010, at 3:00 p.m., the resident stated, "When my husband died I did not have anything to live for." The resident stated the resident had lost weight, but did not care whether the resident ate or not. Resident #5 stated, "I don't care if I see another day and my whole body hurts," and "I'm not crazy and don't need a psychiatrist." Resident #5 verbalized difficulty sleeping and would frequently lie in bed crying at night.</p> <p>A review of the readmission Minimum Data Set (MDS) assessment dated February 2, 2010, revealed the facility assessed resident #5 to have no memory problems and no mood/behavior problems. A review of the annual MDS assessment conducted on May 4, 2010, revealed the facility assessed resident #5 to have no problems with short/long-term memory recall, and to have an unpleasant mood in the mornings, anger, and irritability. Resident #5 was further</p>	F 319			

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F 319	<p>Continued From page 17</p> <p>assessed to express sadness, anger, and/or empty feelings over lost roles/status.</p> <p>A review of the Resident Assessment Protocol Summary (RAPS) dated May 4, 2010, revealed resident #5 continued with all existing medical diagnoses as per prior assessments and medical history. The RAP noted the resident continued to receive routine antidepressant/anti-anxiety medications per physician's order. The RAP stated the resident had recently experienced difficulty sleeping, a hypnotic was prescribed, and the resident verbalized more restful/better sleep. However, there was no evidence the facility had considered/evaluated the possible causative factors related to the resident's mood symptoms.</p> <p>A review of the comprehensive care plan dated May 14, 2009, revealed the facility addressed the potential for impaired adjustment related to recent admission to the facility and diagnoses of Depression and Anxiety. Interventions included a visit from the Social Services Department weekly or when needed and to encourage the resident to ask questions, to express fears and concerns. The care plan was updated on May 4, 2010, to reflect recent complaints of impaired sleep, and new interventions were added to monitor the resident's moods every shift and to report to the physician any worsening or emergence of new mood/behavior indicators and any continued complaints of impaired sleep pattern.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #1 on May 25, 2010, at 10:20 a.m., revealed resident #5 had talked with CNA #1 about the resident's spouse and expressed feelings of "nothing to live for" approximately three to four months ago. CNA #1 stated the</p>	F 319		

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F 319	<p>Continued From page 18</p> <p>CNA reported these comments to the nurse (could not recall the name) and the nurse was going to talk to resident #5. CNA #1 stated the resident had not verbalized any further negative comments.</p> <p>CNA #3 stated in an interview conducted on May 25, 2010, at 10:30 a.m., the resident had talked about the resident's deceased husband approximately six to eight months ago, but the resident's mood seemed to have improved after the resident's knee replacement had healed. However, CNA #3 stated last week when resident #5 was leaving the facility for a physician's appointment, the CNA heard resident #5 talking to the resident's roommate. CNA #3 stated resident #5 said he/she did not care if the R-TEC driver had an accident and killed the resident (resident #5) as long as the driver was uninjured. CNA #3 stated the CNA reported these comments immediately to RN #1.</p> <p>An interview conducted with RN #1 on May 25, 2010, at 10:40 a.m., revealed the RN could not recall CNA #3 reporting the comments related to the R-TEC driver. RN #1 stated resident #5 received Xanax daily due to complaints of being "nervous." RN #1 stated the RN did not question resident #5 for possible causes of nervousness. The RN further stated resident #5 usually spoke about getting better and was happy about losing weight.</p> <p>A review of the Social Services Progress notes dated August 18, 2009, revealed resident #5 was alert/oriented, was pleasant, cooperative with no behavior problems. There were no further social service notes until February 16, 2010, when the Social Services Director (SSD) noted resident #5</p>	F 319			

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F 319	Continued From page 19 continued to be alert/oriented with no behavior problems. The most recent social service note dated May 11, 2010, revealed resident #5 continued to be alert/oriented and was spending most of the time in the resident's room, but did attend Bingo on May 10, 2010. There was no evidence the SSD had provided resident #5 with the weekly visits to address the resident's symptoms of depression. In addition, there was no evidence the facility had evaluated/monitored for the specific behavioral/depression symptoms or possible suicidal tendencies for resident #5 when the resident was readmitted to the facility on January 28, 2010.  An interview conducted with the SSD on May 25, 2010, at 5:55 p.m., revealed the SSD had not reviewed the psychiatric evaluation conducted for resident #5 on January 25, 2010, and was not aware of the resident's depression symptoms. The SSD stated the SSD did participate in the comprehensive assessment and development of the care plan; however, the SSD was not aware of the intervention to conduct weekly visits with resident #5. The SSD further stated if she had been aware of the psychiatric evaluation conducted on January 25, 2010, the SSD would have monitored/counseled resident #5 more frequently.	F 319			
F 323 SS=H	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.	F 323	F 323 Free of Accident Hazards/Supervision/Devices  1. (a). June 2-11, 2010 a Licensed Nurse conducted body assessments on Residents # 1, 8, 15, 29, 33, 34 and 35 to assure residents did not have any injuries the facility was not aware of and had not been investigated. Licensed Nurses conducted fall		

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F 323	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe environment and adequate supervision to prevent accidents for seven (7) of thirty-six (36) sampled residents (residents #1, #8, #15, #29, #33, #34, and #35). The facility failed to evaluate the risk factors and develop/implement resident-specific interventions in an attempt to reduce accidents for these residents.</p> <p>Resident #1 was identified to be at high risk for falls and sustained (6) six falls at the facility from December 10, 2009 to March 23, 2010. On December 21, 2009, the resident fell and sustained a fractured wrist. Resident #29 was identified to be at high risk for falls and sustained nine (9) falls from December 2009 until May 2, 2010. On May 2, 2010, resident #29 fell and sustained two (2) lacerations with bruising to the face, a fractured wrist, and multiple skin tears. Resident #35 was identified to be at high risk for falls and sustained nine (9) falls from November 6, 2009 until May 15, 2010. On May 10, 2010, resident #35 fell and sustained a compression fracture to the spine.</p> <p>In addition, residents #8, #15, #33, and #34 were assessed to be at risk for falls. Resident #8 sustained (14) fourteen falls from January 23, 2010 through May 20, 2010, resident #15 sustained six (6) falls from August 27, 2009 through April 10, 2010, resident #33 sustained five (5) falls from November 11, 2009 through May 1, 2010, and resident #34 sustained five (5) falls from January 13, 2010 through May 5, 2010.</p>	F 323	<p>(Continued from page 20)</p> <p>assessments on Resident's # 1, 8, 15, 29, 33, 34 and 35 between June 24-28, 2010 and care plans were reviewed and revised accordingly. (b) The mouthwash in Resident # 10's room was discarded. The Silvadene Cream was removed from Resident # 12's bedside table and stored appropriately. The Antacid tablets, peri-wash, shaving cream and lotion were removed from Resident # 24's bedside table and bathroom sink and stored appropriately.</p> <p>2. (a) All other residents had the risk of being affected due to age, intrinsic and extrinsic factors. A Licensed Nurse conducted body assessments of all in house residents from June 2 to June 11, 2010 to assure the residents did not have any injuries the facility was not aware of and had not been investigated. A Licensed Nurse conducted fall assessments of all in house residents between June 24 and June 28, 2010 and revised care plans accordingly. (b) Audits were conducted of all resident rooms and common resident areas by various departments (nursing, maintenance, housekeeping, assessment nurses, unit managers, infection control nurse, business office, administrator, dietary) between May 26, 2010 to June 11, 2010 and continue through present day to assure personal items were and are being stored appropriately and that the</p>	

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F 323	<p>Continued From page 21</p> <p>The facility failed to conduct a thorough investigation into the fall incidents to identify possible causal factors related to each fall and failed to develop interventions to prevent further falls for these residents.</p> <p>In addition, containers of toiletry items, peri-wash, antacids, bottles of mouthwash, and medicated ointments were observed to be improperly stored in the resident rooms for three (3) of the twenty-six sampled residents (residents #10, #12, and #24).</p> <p>The findings include:</p> <p>1. A review of the medical record for resident #1 revealed the resident was admitted to the facility on December 9, 2009, with diagnoses that included Cerebrovascular Accident, Hypertension, Gastroesophageal Reflux Disease, Irritable Bowel Syndrome, Hypothyroidism, and Delirium.</p> <p>A review of the admission nurse's notes revealed resident #1 had multiple bruises over the body. The report received from the transferring facility revealed the bruises were due to a fall sustained at the transferring facility earlier on December 9, 2009. Further review of the nurse's notes revealed a personal and a pressure alarm were initiated at admission.</p> <p>A comprehensive admission Minimum Data Set (MDS) assessment dated December 26, 2009, revealed the facility assessed resident #1 to have sustained falls within the previous 30-day period.</p> <p>A review of the Resident Assessment Protocol</p>	F 323	<p>(Continued from page 21)</p> <p>residents' environment was as free of accident hazards as is possible.</p> <p>3. (a) Policies and procedures related to accident/incidents investigation and reporting, management of falls and falls risk, fall risk assessment and accident hazards was reviewed and revised by the Director of Nurses (DON). A new assessment tool was developed to further investigate risk factors and causes of falls/injuries. The assessment tool is to be utilized by the nursing staff and the care planning team to update and revise the resident's plan of care. A new resident assessment protocol (RAP) was developed utilizing data from the minimum data set 2.0 and 3.0. Assessment nurses and the care planning team will utilize this RAP to further evaluate residents' risk for falls and to update the residents' plan of care. Licensed nurses will conduct 72-hour post-fall assessment on residents. On May 26-27, 2010, June 1, 2010, and June 28-29, 2010 the DON re-educated all departments on the residents and environment being as free of accident hazards as possible. On the same dates the DON further educated the nursing staff related to intrinsic and extrinsic resident risks for falls/injury, assessment and investigation into falls/injuries as well as being proactive instead of reactive to falls/risks. (b) Storage containers have been purchased by the facility</p>		

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F 323	<p>Continued From page 22</p> <p>Summary (RAPS) revealed the resident was alert, oriented to person and place, but exhibited confusion at times. The RAPS further revealed the resident was moderately impaired with decision-making and needed frequent cueing and observation to maintain safety. The resident was noted to attempt to get up by herself and had sustained three recent falls.</p> <p>A review of the Fall Risk Assessment dated December 9, 2009, revealed the facility had assessed resident #1 to be at high risk for falls.</p> <p>A review of the plan of care dated December 9, 2009, revealed the resident utilized a personal alarm and a pressure alarm at all times.</p> <p>Observations of resident #1 on May 23, 2010, at 4:00 p.m., revealed the resident to be sitting in the day room with other residents. A personal alarm was in place.</p> <p>A review of the facility's policy dated August 29, 2002, regarding falls prevention revealed the facility was to conduct an investigation into causative factors of the fall whenever a resident sustained a fall. The policy further stated during the investigation the staff would consult other interdisciplinary team members to individualize the resident's needs/interventions on the plan of care.</p> <p>A review of the nurse's notes dated December 10, 2009, at 6:55 p.m., revealed resident #1's personal alarm sounded and staff found the resident on the floor. Further review revealed no injuries were sustained as a result of the fall. A review of the nurse's notes dated December 13, 2009, at 2:00 p.m., revealed resident #1 had</p>	F 323	<p>(Continued from page 22)</p> <p>and the residents' personal items are being stored in those containers. The DON re-educated all departments on May 26-27, 2010, June 1, 2010, and June 28-29, 2010 related to the residents' personal items being stored appropriately.</p> <p>4. (a) The DON and/or designee will maintain a log (ongoing) to track and trend falls over time. The DON and/or designee will analyze the data related to shift, time of day, location, injury and other individual data as is relevant and report findings to QA Committee monthly for the next 12 months. Members of the care planning team will meet each morning Monday-Friday to further review and investigate causes into falls/injuries and to review/recommend further interventions for fall prevention if necessary. Unit Managers will report at the same meeting pertinent information related to the 72 hour post fall assessments. (a). (b). The Unit Managers, ADON/Infection Control Nurse and DON will conduct random audits monthly on all three (3) shifts to assess for safety hazards, fall risks and storage of personal items for the next six (6) months. Information from the audits will be forwarded to the QA Committee monthly for six (6) months.</p>	7/4/10

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F 323	<p>Continued From page 23</p> <p>removed the personal alarm and walked out into the hallway several times during the shift to look for the bathroom. Further review of the nurse's notes dated December 13, 2009, at 9:45 p.m., and December 20, 2009, at 3:00 p.m., revealed resident #1 removed the personal alarm and ambulated out to the hallway without assistance. The nurse's notes further revealed staff was instructed to observe for the removal of the personal alarm.</p> <p>A review of the Incident Report dated December 21, 2009, at 6:05 a.m., revealed resident #1 was found on the floor of the resident's room. The report stated resident #1 had removed the personal alarm. The report indicated resident #1's left wrist was observed to be swollen and the resident complained of pain in the wrist. According to the Incident Report, the resident was transported to the Emergency Department and admitted to the acute care facility with a fractured left wrist.</p> <p>When the resident returned to the facility on December 24, 2009, the Unit Manager stated he updated the resident's "falls" care plan to include an electric low bed for resident #1. Further review of the medical record revealed on December 26, 2009, at 3:30 a.m., resident #1 was found on the floor with a pillow under the resident's head. The resident stated, "I'm not hurt, I took my alarm off and slid out of bed." No injuries were assessed following this fall. Resident #1's plan of care was updated to include "keep bed in low position."</p> <p>Nurse's notes dated December 29, 2009, at 4:00 p.m., revealed the resident was sitting in the wheelchair at the nurses' station, leaned forward,</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>and fell out of the chair. No apparent injury was noted. The resident's plan of care was updated, "When up in wheelchair, observe for safe positioning."</p> <p>Nurse's notes dated January 16, 2010; at 2:10 a.m., revealed resident #1 was found on the floor with the personal alarm attached. No apparent injuries were noted following the fall.</p> <p>Nurse's notes dated January 27, 2010, at 5:00 a.m., revealed resident #1 was found on the floor and stated to staff that the resident had "followed my arm and rolled out of bed." The resident's plan of care was updated to include a pressure alarm to the bed at all times and a pillow placed against the side rail to help support the resident's arm.</p> <p>On March 23, 2010, at 11:45 a.m., resident #1 fell from the toilet and sustained a 0.5 centimeter cut to the left eyebrow. The care plan was updated to include, "Do not leave the resident unattended when up in the room/bathroom, in the wheelchair or in the shower chair."</p> <p>There was no evidence the facility evaluated the individual risk factors related to resident #1's falls, no evidence the facility determined if staff had implemented the care plan interventions at the time of each fall and no evidence the facility monitored the effectiveness of the interventions to prevent further falls for resident #1.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #5 on May 25, 2010, at 2:15 p.m., revealed the resident used to remove the personal alarm "all the time." The CNA further stated the resident removed the alarm no matter where it</p>	F 323		

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F 323	<p>Continued From page 25</p> <p>was placed. According to the CNA, the resident did not seem to be bothered by the personal alarm now.</p> <p>An interview with Licensed Practical Nurse (LPN) #3 was conducted on May 25, 2010, at 2:20 p.m., and revealed the LPN was aware the resident removed the personal alarm. The LPN stated staff "tried to stay with her," and the resident was not supposed to be alone in the resident's room. According to the LPN, "That didn't happen."</p> <p>An interview with the Unit Manager (UM) conducted on May 25, 2010, at 9:55 a.m., and again at 11:15 a.m., revealed the facility's procedure was for the nurse on duty to complete a "Post Fall Assessment" form after a resident sustained a fall and submit the form to the UM. The UM stated the staff has a meeting each weekday morning to discuss the falls. The UM further stated no in-depth review was done to assess risk/causative factors as required by the facility's falls policy.</p> <p>An interview with the Assistant Director of Nursing (ADON) conducted on May 25, 2010, at 3:35 p.m., confirmed the staff met daily to discuss resident falls; however, the ADON stated no one documented these meetings.</p> <p>An interview with the Director of Nursing (DON) conducted on May 25, 2010, at 11:05 a.m. and 2:25 p.m., revealed there was no further investigation/documentation regarding resident falls except the Post Fall Assessment form completed by the nurse on duty at the time of the fall.</p> <p>2. A review of resident #29's medical record</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>revealed the resident was admitted to the facility on November 1, 2005, with diagnoses that included Fractured Pelvis, Anxiety, Anemia, Cardiac Dysrhythmias, and Dysphagia. Review of resident #29's Fall Risk Assessments dated January 17, 2009 and May 9, 2010, revealed the facility assessed resident #29 to be at high risk for falls.</p> <p>Observations of resident #29 on June 23, 2010, at 11:10 a.m., revealed resident #29 in a recliner at bedside with mats on the floor, and motion sensor alarms attached to each side of the bed's footboard. Resident #29 was alert and responded to questions; however, content of the responses made by the resident were not always appropriate.</p> <p>Review of resident #29's Incident Reports revealed the resident fell/slid out of bed six times from December 6, 2009 through February 17, 2010. Although interventions were implemented after the resident sustained each fall, there was no evidence the facility evaluated/investigated the circumstances of the falls to ensure the interventions were appropriate, and resident-specific, in an effort to reduce future falls.</p> <p>An interview was conducted on June 23, 2010, at 6:35 p.m., with the certified nursing assistant (CNA) who was providing care for resident #29. The CNA revealed resident #5 had "panic attacks, itches all over, and peels (his/her) clothes off." The CNA went on to explain the resident would become very anxious, fidgety, and attempted to get out of bed when he/she experienced one of the "panic attacks." The CNA stated resident #29 required "extra checks" during</p>	F 323		

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F 323	<p>Continued From page 27</p> <p>the episodes, and stated, "I think [the attacks] caused some of the falls." However, a review of resident #29's plan of care dated January 21, 2010, revealed the problem had not been identified as a possible contributing factor to the falls, or interventions initiated to address the "panic attacks."</p> <p>Further review of incident reports for resident #29 revealed the resident sustained a fall from the recliner on February 27, 2010, sustaining a skin tear and bruising, and non-skid material was added to the resident's recliner and wheelchair. On March 18, 2010, resident #5 again sustained a fall from the recliner, however, there was no evidence the facility evaluated the effectiveness of the non-skid material or initiated further interventions to prevent falls from the recliner/chair. Although resident #29's care plan was updated on March 19, 2010, to include the intervention of reminding the resident to utilize the call light, an interview with the Unit Manager on June 23, 2010, at 4:15 p.m., revealed resident #1 understood instructions at the time given, "but soon forgot."</p> <p>An Incident Report dated May 2, 2010, at 11:55 a.m., revealed a nursing assistant transferred resident #29 to a wheelchair, left the resident unattended in the hallway, and upon return found the resident in the "fetal position" on the floor. Resident #29 sustained two lacerations to the forehead, skin tears to the left lower eyelid and left wrist, bruising and swelling to both eyes, and neurological responses were sluggish. Resident #29 was transferred to the Emergency Room, and review of a hospital consultation dated May 5, 2010, revealed resident #29 sustained a distal radius fracture which required surgical</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702</b>		
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F 323	<p>Continued From page 28</p> <p>intervention, and a laceration to the left forehead that required sutures.</p> <p>A review of resident #29's care plan on June 23, 2010, revealed the only intervention initiated after resident #29 sustained the fall with injury on May 2, 2010, was an Occupational Therapy (OT) screening for positioning, and subsequent treatment five times a week by OT.</p> <p>3. A review of resident #35's medical record revealed the resident was admitted to the facility on July 1, 2009, with diagnoses that included Alzheimer's Disease, Osteoporosis, Recurrent Urinary Tract Infections, and a History of Falls.</p> <p>A review of a comprehensive admission Minimum Data Set (MDS) assessment and a quarterly MDS assessment dated July 10, 2009 and April 5, 2010, revealed the facility assessed resident #35 to have sustained falls within the previous 30-day period and falls within the previous 31 to 180-day period.</p> <p>A review of resident #35's Resident Assessment Protocol Summary (RAPS) dated July 10, 2009, revealed the resident was alert/verbally interactive with staff and others, and able to clearly make wants/needs known. The RAPS further revealed the resident required staff assistance with all ADLs to varying degrees and the resident was ambulatory; however, the resident's gait was unsteady. The resident was noted to have experienced numerous falls at home prior to admission. According to the RAPS, the resident's last fall occurred approximately three weeks prior, and the resident sustained no significant injuries.</p> <p>A review of the Fall Risk Assessments dated July</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>1, 2009 and December 27, 2009, revealed the facility assessed resident #35 to be at high risk for falls.</p> <p>Observations of resident #35 on June 23, 2010, at 2:50 p.m., revealed the resident to be lying in bed with a sensory pad under the resident and a personal alarm attached to the resident's shirt.</p> <p>Review of resident #35's Incident Reports revealed resident #35 sustained six falls from November 6, 2009 to March 18, 2010, as a result of sliding from bed/chair or missing the bed/chair when attempting to sit down.</p> <p>A review of the plan of care dated July 10, 2009, revealed resident #35 should be assisted with toileting per the established schedule and as needed, encouraged to wear non-skid shoes, and assisted with ADLs as indicated. Undated revisions to the care plan included encouraging the resident to ring for assistance and to offer assistance to the resident with each contact. On February 26, 2010, the care plan was updated with an intervention to encourage/assist the resident to wear gripper socks at night. On March 8, 2010, the care plan was revised to include utilizing a pressure alarm to the resident's bed at night. On March 18, 2010, the facility added hipsters to the resident's care plan.</p> <p>An Incident Report dated March 14, 2010, at 1:35 p.m., revealed resident #35 was found lying on the right side on the floor by the bed. The resident reported he/she got up and tripped on the overbed table. Bruising was noted to the right eye temporal area. On March 15, 2010, the care plan was updated with an intervention to remove the resident's meal tray and overbed table when</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>the resident was finished with meals.</p> <p>An Incident Report dated May 10, 2010, at 7:15 p.m., revealed resident #35 was looking for clothes in the resident's closet when the resident lost her/his balance and fell backwards onto the floor. According to the medical record, resident #35 complained of pain in the lower back/buttocks. Review of an x-ray of the lumbar spine dated May 11, 2010, revealed "Severe compression deformity of T12 is of uncertain chronicity. There is also mild superior endplate deformity of L3 of unknown chronicity. There is no sclerosis in either area to suggest that these are old fractures." Resident #35's care plan was updated on May 11, 2010, to assist the resident with finding clothes. On May 13, 2010, the care plan was updated with an intervention to administer Lortab three times a day as needed for pain.</p> <p>An Incident Report dated May 15, 2010, at 4:40 p.m., revealed resident #35's roommate reported to staff that resident #35 was on the floor. The resident was found sitting on the floor beside the resident's bed. No injuries were noted. On May 17, 2010, two days later, an intervention was added to the resident's care plan to monitor the resident for use of gripper socks and to encourage the resident to wear the gripper socks with each contact.</p> <p>Review of the Post Fall Assessments for resident #35 revealed no specific information on the assessment, just yes/no questions such as: history of previous falls, able to make decisions, continent/incontinent, use of ambulatory devices, vision/hearing deficit.</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>An interview with the Unit Manager (UM) conducted on June 23, 2010, at 6:30 p.m., revealed if a resident sustained a fall, the nurse working at the time, or the UM, would add new interventions to the resident's care plan as needed. In addition, the UM stated the Incident Report should be reviewed, and the cause of the fall determined. The interview revealed the facility did not conduct and document an investigation into each fall to determine the possible causal factors or track and trend falls to determine if a pattern existed. The UM revealed the facility did not conduct a formal investigation to identify the causal factors of the falls and initiate interventions based on those findings.</p> <p>4. A review of the medical record for resident #8 revealed the resident was admitted to the facility on December 4, 2009, with diagnoses that included Partial Bilateral Hearing Loss, Blindness, and Dementia with Behavior Disturbances, Seizure Disorder, Anxiety Disorder, Malaise, and Fatigue. Resident #8 was assessed by the facility to be at risk for falls related to a history of falls, an unsteady gait, and blindness.</p> <p>Observations of resident #8 on May 23, 2010, at 4:40 p.m., revealed the resident ambulating from the resident's room into the hallway without staff assistance. The resident's gait was observed to be unsteady. No alarms were sounding as the resident exited the room.</p> <p>A comprehensive admission Minimum Data Set assessment (MDS) dated December 17, 2009, revealed resident #8 was severely visually impaired, required extensive assistance with transfers, walking in the corridor, and locomotion on and off the unit. The MDS further assessed</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>the resident to have an unsteady gait and to have sustained a fall within the previous 31 to 180 days.</p> <p>A review of the falls care plan for resident #8 revealed interventions that included monitoring blood pressure as needed for complaints of dizziness or imbalance, to observe when up and assist if unsteady, and pressure alarm to the bed. Further review of resident #8's plan of care revealed the resident had sustained multiple falls with no injuries from January 23, 2010 through May 20, 2010.</p> <p>According to an Incident Report, on January 23, 2010, at 3:30 p.m., the resident was anxious and walking with staff when the resident turned away from the staff member and started walking away, became anxious again, and fell backwards. The resident's care plan had interventions added on January 25, 2010, of "approach calmly, offer assistance, and Ativan as ordered for anxiety."</p> <p>On January 30, 2010, according to the Incident Report, resident #8 fell seven times with no injuries noted. The plan of care was updated to discontinue Ativan, consult with psychiatric services, and add a pressure alarm to the resident's bed and chair at all times.</p> <p>On March 9, 2010, resident #8 rose from the chair, got his/her foot tangled in the chair leg, and fell with no injury. The care plan was updated to "observe when up, assist if unsteady."</p> <p>On March 16, 2010, at 4:45 p.m., the resident tripped over his/her feet and landed on the resident's knees. No injury was noted and Restorative Ambulation was initiated.</p>	F 323			

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F 323	<p>Continued From page 33</p> <p>According to the Incident Report, on March 19, 2010, resident #8 "got tired and sat in the floor." No injuries were apparent and the care plan was updated for staff to assist the resident to lie down if tired.</p> <p>An Incident Report dated April 6, 2010, at 3:15 p.m., revealed staff heard a thud and observed the resident on his/her buttocks against the wall. A reddened area was observed on the resident's lower back. The care plan was updated to include frequent visual checks.</p> <p>According to the care plan for resident #8, the resident tripped and slid down the wall in the hallway on April 14, 2010, at 10:50 a.m.</p> <p>According to an Incident Report dated May 20, 2010, the resident was found on the floor of the resident's room at 6:00 p.m. No injuries were noted and the care plan was updated to assist the resident to toilet when returning to the room following meals.</p> <p>An interview with the UM conducted on May 25, 2010, at 11:05 a.m., revealed the resident was supposed to have a bed alarm; however, when the UM and surveyor observed the resident's bed no bed alarm was in use for resident #8. The UM stated that the UM tried to check all the beds every couple of weeks to ensure that bed alarms were in use if ordered. The UM stated that staff conducted a meeting each morning on weekdays to discuss falls but did not review all risk factors or evaluate previous interventions for effectiveness.</p> <p>5. A review of the medical record for resident #15</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>revealed the resident was admitted to the facility on May 1, 2008, with diagnoses that included Degenerative Joint Disease, Gastroesophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Gout, Arteriosclerotic Heart Disease, and Vitamin B-12 Deficiency. A review of the Incident Reports revealed resident #15 sustained six falls from August 27, 2009 through April 10, 2010. A review of the quarterly Minimum Data Set (MDS) assessment dated March 3, 2010, revealed the facility assessed resident #15 to require extensive assistance with bed mobility, transfers, ambulation in the room and hall, and with locomotion on and off the unit. The MDS further assessed the resident to have an unsteady gait and to have a history of falls.</p> <p>Observations of resident #15 on May 25, 2010, revealed resident #15 to be alert and oriented. Resident #15 was observed to utilize a walker for ambulation and to have an unsteady gait when walking.</p> <p>A review of the Incident Report dated August 27, 2009, at 5:45 p.m., revealed the resident fell in the dining room. The resident stated he/she became dizzy and fell backwards. No injuries were noted.</p> <p>An Incident Report dated December 18, 2009, at 3:05 p.m., revealed resident #15 lost his/her balance and fell in the bathroom. The resident sustained a small skin tear. The care plan was updated to add, "When feeling weak, encourage to ring for assistance."</p> <p>An Incident Report dated January 4, 2010, at 3:00 a.m., revealed resident #15 was found on the floor in front of the recliner. The resident was</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>ambulating to the bathroom and lost balance. The care plan was updated to add use of wheelchair to transport when the resident complains of weakness.</p> <p>On March 24, 2010, at 1:40 p.m., the resident was standing in the doorway to the resident's room and began coughing. The resident's knees buckled and the resident was eased to the floor by staff. The resident sustained a skin tear. The care plan was updated to include a referral to Speech Therapy and to encourage the resident to wear hipsters.</p> <p>On April 1, 2010, at 3:00 a.m., the resident was found leaning on the edge of the tub with his/her knees on the floor. The resident stated he/she was attempting to sit on the toilet and lost balance. The resident sustained a skin tear.</p> <p>An Incident Report dated April 10, 2010, at 10:50 p.m., revealed resident #15 got up unassisted and fell back towards the chest of drawers. No injuries were noted and the care plan was updated to add the use of a personal alarm at bedtime.</p> <p>Review of resident #15's medical record revealed no evidence to indicate the facility had conducted investigations into any of the falls sustained by the resident, nor were previous interventions evaluated for effectiveness.</p> <p>An interview with the Unit Manager (UM) conducted on May 25, 2010, at 9:55 a.m. and again at 11:15 a.m., revealed the facility's procedure after a resident fall was for the nurse on duty to complete a "Post Fall Assessment" form and submit the form to the UM. According</p>	F 323		

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F 323	<p>Continued From page 36</p> <p>to the UM, no other investigation was done related to falls. The UM stated the staff has a meeting each weekday morning and discusses the falls.</p> <p>6. A review of resident #33's medical record revealed the resident was admitted to the facility on July 14, 2009, with diagnoses that included Alzheimer's Disease, Pneumonia, Atrial Fibrillation, Psychosis, Congestive Heart Failure, and Neuropathy.</p> <p>A review of a comprehensive admission Minimum Data Set (MDS) assessment dated October 20, 2009, revealed resident #33 had experienced no falls in the last 180 days. A quarterly MDS assessment dated April 22, 2010, revealed the resident had a fall within the previous 31-180 day period. A significant change assessment dated May 13, 2010, revealed resident #33 had sustained falls within the previous 30-day period and within the previous 31-180 day period. The MDS dated October 20, 2009 and April 22, 2010, revealed the resident's cognition was modified independent.</p> <p>A review of the Fall Risk Assessments dated March 23, 2010 and April 15, 2010, revealed the facility assessed resident #33 to be at high risk for falls.</p> <p>Observations of resident #33 on June 23, 2010, at 11:40 a.m., revealed the resident was dressed in street clothes utilizing a hearing aid, in the therapy room performing leg exercises.</p> <p>A review of the plan of care dated July 22, 2009, revealed the following interventions: encourage the use of non-skid shoes, monitor medication</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>side effects, and assist the resident with ADLs. The review revealed the care plan was updated, with no date documented, for resident #35 to have Physical/Occupational Therapy as indicted and a personal alarm at all times.</p> <p>Review of resident #33's Incident Report dated November 11, 2009, at 11:30 a.m., revealed the resident scooted out of the wheelchair and landed on the floor on the resident's buttocks. According to the Incident Report, resident #35 did not sustain injuries as a result of the fall. An Incident Report dated November 30, 2009, at 11:40 a.m., revealed staff heard resident #33's alarm sounding and found the resident on the floor. Resident #33 reported he/she was attempting to get in bed and the wheelchair rolled out from under the resident. No injuries were noted.</p> <p>An interview with the Unit Manager (UM) conducted on June 23, 2010, at 6:30 p.m., revealed after reviewing resident #33's medical record, Physical Therapy was initiated on November 13, 2009, as a result of the November 11, 2009 fall. In addition, the UM stated on December 3, 2009, the facility placed a personal alarm on resident #33, to be worn at all times.</p> <p>Further review of Incident Reports revealed on April 25, 2010, at 10:30 a.m.; the resident was self-propelling the wheelchair to the resident's room, attempted to self-transfer, and fell. The resident removed the personal alarm, and was found sitting on the floor. On April 25, 2010, the care plan was revised to include offering to assist the resident to bed. There was no evidence of an investigation related to the resident self-transferring, assessment of the personal alarm, or interventions to address the behavior.</p>	F 323			

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F 323	<p>Continued From page 38</p> <p>An Incident Report dated April 29, 2010, at 2:45 p.m., revealed resident #33's roommate summoned staff for assistance because resident #33 was on the floor beside the resident's bed. The report revealed the resident's personal alarm was attached to the resident's bed, however, was not attached to the resident. The resident sustained a skin tear to the right elbow. According to the care plan on April 30, 2010, resident #33 was placed in an electric low bed in the lowest position when the resident was in bed. There was no investigation as to why the resident's personal alarm was not attached to the resident or who removed the alarm. There was no evidence the facility determined if staff had implemented the care plan interventions and no evidence the facility monitored the effectiveness of the interventions to prevent further falls for resident #33.</p> <p>According to an Incident Report dated May 1, 2010, at 8:00 p.m., resident #33 slid out of the wheelchair. The Incident Report stated no injuries were sustained. A review of the care plan revealed no new interventions were added to the care plan after the fall. Interview with the Unit Manager (UM) on June 23, 2010, at 6:30 p.m., revealed on May 3, 2010, anti-skid material was added as an intervention for resident #33. Although the facility added the intervention to the nursing assistant care plan, it was omitted from the comprehensive plan of care.</p> <p>Review of the Post Fall Assessments for resident #33 revealed no specific information related to assessment of falls. The assessment contained yes/no questions such as: history of previous falls, able to make decisions,</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>continent/incontinent, use of ambulatory devices, vision/hearing deficit.</p> <p>An interview with the Unit Manager (UM) conducted on June 23, 2010, at 6:30 p.m., revealed after reviewing the Incident Report and attempting to determine the cause of the fall, the UM would add new interventions to the resident's care plan. The interview revealed the facility did not conduct a documented investigation into the falls to determine the cause or track and trend the falls to determine if a pattern existed and initiate interventions based on those findings.</p> <p>7. A review of resident #34's medical record revealed the resident was admitted to the facility on February 16, 2003, with diagnoses that included Malignant Neoplasm, Hypertension, Non Insulin Dependent Diabetic, and Hypothyroidism. Further review of resident #34's medical record revealed a history of falls in the facility. Review of Fall Risk Assessments dated February 7, 2010, March 17, 2010, and May 30, 2010, revealed resident #34 was assessed to be at high risk for falls.</p> <p>An observation of resident #34 on June 23, 2010, at 2:15 p.m., revealed the resident was lying in bed on the left side. One-fourth side rails were in use on the right side of the bed and no alarms were observed to be in use.</p> <p>A review of resident #34's Minimum Data Set Assessments dated December 10, 2009 and June 4, 2010, revealed the resident required extensive assistance with bed mobility, transferring, and ambulation.</p> <p>Review of resident #34's Incident Reports</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>revealed the resident sustained five falls attempting to self-transfer/ambulate from January 13, 2010 to May 5, 2010. On January 13, 2010, at 4:50 p.m., the resident was found lying on the floor after attempting to self-transfer due to being nauseated. The care plan was updated on January 14, 2010, for staff to frequently remind/encourage the resident to request assistance with transfers. However, an interview on June 23, 2010, at 4:10 p.m., with the Unit Manager (UM) revealed reminding the resident to request assistance was ineffective due to the resident's cognitive status.</p> <p>A review of Incident Reports revealed on January 22, 2010, at 4:30 a.m., resident #34 was found sitting on the floor beside the bed, after attempting to transfer from the bed to the wheelchair. Restorative Nursing was consulted and non-skid socks were implemented. On February 19, 2010, at 12:50 a.m., resident #34 was found sitting on the floor beside the bed, after attempting to transfer unassisted from the bed to the wheelchair. According to the care plan, no new interventions were initiated/revised after the fall.</p> <p>According to the Incident Reports, on April 28, 2010, at 9:30 a.m., resident #34 was found on the floor in the doorway of the bathroom, and was placed on scheduled toileting. On May 5, 2010, at 5:30 p.m., resident #34 was found sitting on the floor beside the bed, after attempting to transfer from the bed to the wheelchair unassisted, and a referral for Physical Therapy (PT) to evaluate and treat was made.</p> <p>An interview was conducted on June 23, 2010, at 4:10 p.m., with the Unit Manager (UM) for</p>	F 323		

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F 323	Continued From page 41 resident #34. The UM stated that although all the falls sustained by resident #34 from January 13, 2010 to May 5, 2010, involved the resident attempting to self-transfer, the facility failed to conduct an investigation of the falls in an attempt to determine why resident #34 continued to attempt self-transfers.  8. A bottle of mouthwash was observed to be sitting on the window sill of resident #10's room on May 23, 2010, at 4:00 p.m. and at 5:20 p.m. The mouthwash was still present on the window sill on May 24, 2010, at 8:25 a.m.  A container of Silvadene Cream was observed to be on resident #12's bedside table on May 23, 2010, at 12:45 p.m., 3:30 p.m., and 6:00 p.m. The Silvadene Cream was again observed on the resident's bedside table on May 24, 2010, at 9:00 a.m.  A bottle of Antacid tablets was observed on resident #24's bedside table, and a bottle of peri-wash, shaving cream, and a bottle of lotion were sitting on the sink in the resident's bathroom during the initial tour conducted on May 23, 2010, at 11:10 a.m.  An interview conducted with the Assistant Director of Nursing (ADON) on May 25, 2010, at 5:40 p.m., revealed toiletry items and medications were not supposed to be stored in the residents' rooms. The ADON stated the facility did not have a policy/procedure to direct the appropriate storage of these items.	F 323		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN  Therapeutic diets must be prescribed by the	F 367	F 367 Therapeutic diets  1. The salt was removed from Resident # 1's tray. The primary care physician	

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F 367	<p>Continued From page 42 attending physician.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were provided therapeutic diets as ordered by the physician for two (2) of twenty-seven (27) residents (residents #1 and #9). Observations on May 23, 2010, revealed staff included salt packets for two (2) residents on "No Added Salt" diets.</p> <p>The findings include:</p> <p>Observations of the supper meal on May 23, 2010, revealed residents #1 and #9 were served salt packets on their meal trays.</p> <p>A review of the physician's orders for resident #1 revealed the physician had ordered a regular, mechanical soft, no-added-salt diet for the resident. A review of the physician's orders for resident #9 revealed the physician had ordered a reduced carbohydrate, no-added-salt diet.</p> <p>An interview with the Certified Nurse Aide (CNA) who served trays to the residents was conducted at 5:25 p.m. on May 23, 2010. The CNA stated the salt packet was included on the tray when the CNA took it from the kitchen.</p> <p>An interview with the Dietary Aide (DA) conducted at 6:00 p.m. on May 23, 2010, revealed the DA had assembled the tray and the tray card was not with the tray at the time it was assembled.</p> <p>An interview with the Dietary Manager (DM) was</p>	F 367	<p>(Continued from page 42) was informed about Resident # 9 receiving salt and the physician assessed Resident # 9 on June 6, 2010 with no new orders.</p> <ol style="list-style-type: none"> <li>All residents prescribed a therapeutic diet could have been affected. The dietary manager and the Registered Dietitian audited physician orders, tray cards and observed the tray line to assure other residents received therapeutic diets as prescribed by the physician. No other residents were identified.</li> <li>On June 1, 2010 and June 8, 2010 the dietitian re-educated the dietary staff on the importance of providing each resident with the diet as prescribed by the physician. On May 26-27, 2010, and June 1, 28-29, 2010 the DON re-educated nursing staff on providing diet as ordered by the resident's physician and on the importance of reading each resident's tray card at the point of service to assure diets were provided to residents as prescribed by the physician.</li> <li>For the next six (6) months the Registered Dietitian (RD) and/or the Dietary Manger (DM) will conduct a monthly audit of the tray line to assure residents are provided with the physician prescribed diet. The RD/DM will report findings to the QA Committee monthly for the next six (6) months. For the next six (6) months</li> </ol>	

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F 367	Continued From page 43	F 367	(Continued from page 43)	
F 431 SS=F	<p>conducted at 6:00 p.m. on May 23, 2010. The DM stated both resident #1 and resident #9 were noncompliant with their diet and would request salt if it was not included on the tray.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p>the DON, ADON &amp; Unit Managers will conduct a point of service audit on 30 residents a month to assure residents are provided with therapeutic diets as prescribed. Findings will be reported to the QA Committee monthly for six (6) months.</p> <p>F 431 Pharmacy Services</p> <ol style="list-style-type: none"> <li>(a) Licensed Nurses inspected the second floor medication room and medication carts on May 25, 2010. The Timolol Maleate was discarded and new medication was obtained. On May 25, 2010 the following items were discarded. The 34 blue top vacutainers dated January 2010, the Bac T/Alert SA (blood culture vials) dated March 31, 2010 and April 30, 2010 were discarded. The third floor medication refrigerator was inspected by Licensed Nurses on May 25, 2010. The following items were discarded on May 25, 2010. The Bac T (blood culture vials) dated April 30, 2010. The 94 Bisacodyl Suppositories, 231 Acetaminophen Suppositories, 29 Hemorrhoid Suppositories, 28 Anucort Suppositories, ten Phenergan Suppositories, two Compazine Suppositories, two Aspirin Suppositories, nine vials of Lantus Insulin, six vials of Novolin R Insulin, ten vials of Novolin 100 Insulin, four vials of Levemir Insulin and one vial of Procrit. The pharmacy was notified</li> </ol>	7/4/10

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F 431	<p>Continued From page 44</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were stored safely and at the appropriate temperatures. Multiple medications were observed to be stored at improper temperatures in the third floor medication refrigerator. One (1) eye medication had been opened; however, the bottle was not dated to indicate the date the bottle was opened. In addition, Vacutainer/blood culture vials utilized for performing venipuncture were expired and available for resident use. Additional observations revealed the medication cart was left unattended and unlocked during medication administration on May 24, 2010.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Observation of the facility's second floor medication room conducted on May 25, 2010, at 4:00 p.m., revealed one bottle of Timolol Maleate 0.5% was stored in the medication cart. The medication had been opened; however, the bottle was not dated to indicate the date the bottle was opened.</li> </ol> <p>Additional observations on May 25, 2010, at 4:00 p.m., revealed 34 blue top Vacutainers had an expiration date of January 2010, one Bac T/Alert SA (blood culture vial) had an expiration date of April 30, 2010, and one Bac T/Alert SA (blood culture vial) had an expiration date of March 31, 2010, and remained available for resident use.</p> <p>Observation of the facility's third floor medication</p>	F 431	<p>(Continued from page 44)</p> <p>and responded by their staff returning to the pharmacy and providing new medications for the residents and delivering them on the same night (May 25, 2010). The temperature of the third floor refrigerator was assessed frequently for the next six days and did have to be adjusted on three occasions and was rechecked within an hour and temperature was between 36 and 46 degrees. A new refrigerator was purchased for third floor medication room. The air conditioner compressor was replaced. The second and third floor medication rooms were evacuated and medications were stored in an appropriate area until necessary repairs/corrections were made. (b). The medication cart was locked as soon as this was brought to nurse # 1's attention.</p> <ol style="list-style-type: none"> <li>2. All residents had the potential to be affected. Licensed Nurses inspected the second and third floor medication rooms, medication refrigerators and medication carts on May 25, 2010 any unlabeled medications, expired biologicals or temperature sensitive medications were discarded. The pharmacy was notified and new medications were obtained for residents. (b). Nurses and medication aides were re-educated verbally on May 25, 2010 and May 26, 2010 by the Director of Nursing that the medication carts must be locked at all times if they</li> </ol>		

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F 431	<p>Continued From page 45</p> <p>room conducted on May 25, 2010, at 4:30 p.m., revealed three Bac T (blood culture vials) had an expiration date of April 30, 2010, and were available for resident use.</p> <p>Additional observations of the third floor medication room revealed the thermometer located inside the medication refrigerator indicated the temperature was 58 degrees Fahrenheit. According to the label on the thermometer, this reading would be considered "spoilage." According to the temperature guidelines, the refrigerator temperatures should be maintained between 36 degrees Fahrenheit and 46 degrees Fahrenheit. A review of the monthly refrigerator temperatures recorded for May 2010 revealed the temperature ranged from 36 degrees Fahrenheit to 42 degrees Fahrenheit. The medication refrigerator contained 94 Bisacodyl Suppositories, 231 Acetaminophen Suppositories, 29 Hemorrhoid Suppositories, 28 Anucort Suppositories, ten Phenergan Suppositories, two Compazine Suppositories, two Aspirin Suppositories, nine vials of Lantus Insulin, six vials of Novolin R Insulin, ten vials of Novolin 100 Insulin, four vials of Lovemir Insulin, and one vial of Pro-crit.</p> <p>Additional observation conducted on May 25, 2010, at 5:30 p.m., revealed the refrigerator temperature was 55 degrees Fahrenheit.</p> <p>Interview on May 25, 2010, at 5:30 p.m., with the staff nurses from the second and third floors revealed no specific staff was assigned to check for expiration dates on laboratory supplies and that all multi-dose bottles/vials should be dated when opened. The third floor staff nurse stated the medication refrigerator temperatures should</p>	F 431	<p>(Continued from page 45)</p> <p>were not actually getting medications from the carts.</p> <p>3. (a) The Director of Nursing reviewed the pharmacy policies and procedures related to locking of medication carts, dating of multi-dose vials when opened and appropriate storage and temperatures of drugs and biologicals. Re-education of nursing department was conducted on May 26-27, 2010, June 1, 2010 and June 28-29, 2010 by the Director of Nursing related to temperatures of refrigerators, medication room temperatures, labeling and dating of multi-dose vials, supplies, etc., checking expiration dates and discarding drugs/biologicals, and/or any other supplies based upon expiration dates of products. The re-education further explained it was necessary for manufacturer recommendations be read and medications stored based on those guidelines. Education was also given related to locking of medication carts and at least daily temperature checks of medication refrigerators, medication rooms and noticing/checking temperature throughout the day. If noted to be too warm or too cold by staff what actions to take if temperature remains above or below approved standards for more than one hour. A facility pharmacy technician will be added to the staffing pattern.</p>	

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F 431	Continued From page 46 not exceed 46 degrees Fahrenheit. The third floor staff nurse stated the elevated temperature could be a result of the nurses opening the door to remove the Insulin.  Review of the facility's policy revealed medication refrigerator temperatures should be maintained between 36 degrees Fahrenheit and 42 degrees Fahrenheit.  2. Based on observation of a medication pass on May 24, 2010, between 1:26 p.m. and 1:56 p.m., LPN #1 left the medication cart unlocked and unattended in the hallway out of sight while administering residents' medications two times while passing medications to five residents.  Interview with LPN #1 conducted on May 24, 2010, at 2:20 p.m., revealed the medication cart was to be locked at all times when left unattended and out of sight. LPN # 1 stated, "I just got very nervous and forgot to lock the cart."  Review of the facility's policy on medication Preparation and General Guidelines (no date) revealed the medication cart was required to be kept closed and locked when out of sight of the medication nurse during administration of medications. The facility's policy further stated the medication cart must be clearly visible to the personnel administering medications.	F 431	(Continued from page 46)  4. For the next six (6) months the pharmacy technician will conduct monthly audits of the second and third floor medication rooms and medication refrigerators for temperature, appropriate dating of meds/biologicals when opened, expiration dates of other time sensitive supplies such as lab supplies and appropriate discarding of all drugs, supplies and biologicals. The results of the monthly audits will be reported to the QA Committee monthly for the next six (6) months. For the next 12 months a Med-Care Pharmacy representative will conduct a monthly audit of the second and third floor medication rooms, medication refrigerators, medication carts, treatment carts, for appropriate storage, labeling and discarding of medications. Results of the Pharmacy Representative audits will be forwarded to the QI Committee monthly for the next 12 months.	and/or nurse  7/4/10	
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.	F 441	F 441 Infection Control  1. Staff was promptly re-educated on hand washing. The ice machine was taken out of service, emptied and cleaned appropriately. Ice machines and ice carts have been locked and stored appropriately.		

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F 441	Continued From page 47  (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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure an infection control program was implemented. Facility staff failed to wash their hands during meal tray pass conducted on May 23, 2010, at	F 441	(Continued from page 47) 2. All residents had the potential to be affected. On May 26-27, 2010 the infection control nurse conducted a random audit on employee hand washing. An audit was conducted of common resident areas on first, second and third floors to assess for further infection control issues. Appropriate actions were taken based on findings.  3. (a.) (b). The infection control nurse and DON reviewed/revised the infection control policy and procedure. The DON re-educated all departments related to infection control practices on May 26-27, 2010, June 1, 2010 and June 28-29, 2010.  4. The infection control nurse or designee will conduct monthly audits for the next 12 months to assure infection control practices are being followed. Findings will be reported monthly to the QA Committee for the next 12 months. For the next 12 months the Director of Nursing will conduct random quarterly audits to assure infection control practices are being followed. The random audits will be presented to the QA Committee quarterly for the next 12 months.	6/30/10

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F 441	<p>Continued From page 48</p> <p>5:36 p.m., after direct resident contact for which handwashing was indicated by accepted professional practice. In addition, on May 24, 2010, at 3:50 p.m., an unsampled resident was observed obtaining ice from the ice machine on the second floor using a personal cup to dip into the ice.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Observation conducted during the evening meal on May 23, 2010, at 5:36 p.m., revealed Certified Nurse Aide (CNA) #2 removed the bed linen from an unsampled resident and placed the resident's leg onto the bed, set up the resident's tray, and touched the resident's hamburger while cutting the sandwich on the resident's plate. CNA #2 was then observed to go to the meal tray cart and remove another resident's tray and delivered the tray to that resident without performing handwashing or sanitizing the CNA's hands after providing care for the resident.</li> </ol> <p>Interview on May 23, 2010, at 5:55 p.m., with CNA #2 revealed the CNA had been trained to perform handwashing or sanitizing of her hands between each individual resident contact, such as repositioning residents and serving trays to the residents.</p> <p>Review of the facility's policy on handwashing (dated December 1998) revealed stated facility staff was required to perform handwashing before preparing or handling medications, after removing gloves, upon completion of a duty, or whenever in doubt.</p> <ol style="list-style-type: none"> <li>2. Observations on May 23, 2010, of the ice machine on the second floor revealed the ice</li> </ol>	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/24/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702</b>		
(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 441	<p>Continued From page 49</p> <p>machine was equipped with a small unlocked padlock. Observation of the third floor ice machine revealed a hasp attached to the lid, but no lock on the machine. Observation on May 24, 2010, at 3:50 p.m., revealed a resident opened the second floor ice machine door and dipped the resident's cup into the ice.</p> <p>An interview was conducted with CNA #6 on May 24, 2010, at 6:25 p.m. CNA #6 stated some residents do get ice from the machine and the CNAs were supposed to keep the ice bin locked.</p> <p>An interview with LPN #6 on the second floor conducted on May 24, 2010, at 6:30 p.m., revealed that it was the responsibility of the CNAs to ensure the ice machines were locked; however, the nurses were to monitor to ensure that the locks were in place.</p> <p>An interview with the Unit Manager (UM) conducted on May 25, 2010, at 7:55 a.m., revealed the ice machines were to be locked at all times. The UM stated he was unaware the ice machines were not being locked.</p>	F 441			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185232</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/26/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702</b>		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on May 26, 2010, for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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.