

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

PRINTED: 05/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2010
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203	
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F 000	INITIAL COMMENTS A standard survey was conducted 05/11/10 through 05/13/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews it was determined the facility failed to maintain a sanitary interior. The facility was found to have rust stains in bathtubs, resident equipment was dirty, floors were dirty, cracked tiles, garbage cans over filled and boxes stored on the floors. The findings include: Observations during the environmental tour on 05/11/10 at 8:00am revealed room 235 had dolls sitting on the over bed light, room 135 had a large rust stain in the bathtub, room 134 was noted with a raised toilet seat on the commode with a brown substance on the seat. Rooms 203 and 218's floors were dusty with brown spots. The 2nd floor shower room whirlpool had chips in the finish. Observations on 05/11/10 and 05/12/10 revealed room 134 had an IV pole with a dried substance on it and the floor under the pole. In addition, the	F 253	F253 1) All areas noted to be non-compliant in the surveyor's report were addressed. Facility management did confirm that the therapy technician referenced in the report was properly trained on her required duties.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Raymond A. [Signature]

Executive Director

6/7/10

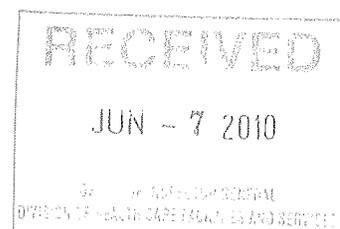
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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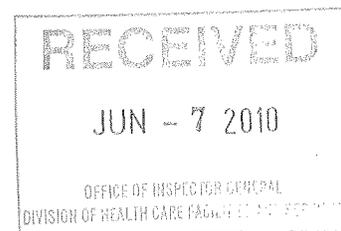
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F 253	<p>Continued From page 1</p> <p>elevator button was noted to be cracked with a piece missing and the plastic that remained had a sharp edge.</p> <p>Observations on 05/13/10 at 8:07am revealed the hydrocolator stored in the therapy department had dried white particles on the sides, front and top; the water level was low and appeared yellow in color. The utility cart holding the hydrocolator was dirty with white particles. The floor of the storage area (containing resident equipment) was littered with pieces of paper, a can top, and a dead roach. The sink in this room was dirty with dried white particles, bits of dust and paper noted in the drain. The DME (durable medical equipment) storage room had numerous splints and braces stored on the floor. The floor was littered with debris and dust. The OT (Occupational Therapy) area revealed a microwave with dried food splashes, an open bag of sugar on the counter, the garbage can was overflowing with trash, the floor tiles in the OT area were cracked and raised approximately 4 inches across and the kitchen floor was dirty with a brown substance.</p> <p>Observations on 05/13/10 at 9:35am of the Central Supply room revealed numerous boxes of resident supplies sitting on the floor. Room 222 had a rust stain in the bath tub near the drain and the faucet was dripping. Room 103 doorway and floor were dusty and there was a sign on the bathroom door stating out of order. The bathroom had a blanket on the floor around the base of the toilet and it was soaking wet. Rooms 131 and 134 had dust caked in the corners of the room and the floor was dirty with dried substances.</p>	F 253	<p>2) The Executive Director will ensure that an audit will be completed by maintenance, environmental services, nursing and administrative staff of all resident over-the-bed lights, bathtubs, raised toilet seats, IV poles, elevator buttons, hydrocollator, central supply area, resident sink faucets and whirlpool tubs. In addition, all facility floors will be audited for cleanliness and evidence of broken tiles. Areas noted for improvement will be cleaned, repaired or replaced as indicated.</p> <p>3) Random audits will be done by the Maintenance Director and Environmental Services Director monthly on all items noted for audit as referenced in #2.</p> <p>4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance.</p> <p>Date of Completion: June 27, 2010</p>	



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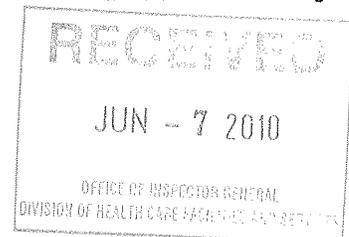
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F 253	Continued From page 2 Interview with the Housekeeper on 05/13/10 at 10:05am revealed the blanket was placed on the floor yesterday and the problem would be fixed today. Interview with the Maintenance Director on 05/13/10 at 1:00pm revealed the water valve was not shut off tight enough after someone cleaned a bed pan. Interview with the Housekeeping Supervisor on 05/13/10 at 10:50am revealed they had worked on some of the floors but could not strip the floors every day. There are two people on days and a floor person has Tuesday, Wednesday and Thursday to do the floors. Interview with the Maintenance Director on 05/13/10 at 12:50pm revealed the elevator button was hit by a cart and was logged for Murphy elevator to fix last week; however, according to the Maintenance Director it would not be fixed until the scheduled monthly service this week or next week. Interview with the Speech Therapist on 05/13/10 at 8:55am revealed cleaning of the storage area was a group effort. No one specific person was responsible for keeping it clean. The therapy staff do not clean the hydrocolator but concentrate on the inside. The logs were not kept up to date, and the sink is rarely cleaned. In addition, it was noted many of the things on the floor are not in use but could potentially be used. The storage room is actually used for sewage ejection. The microwave oven was last cleaned on Monday (05/10/10). The staff could not remember how long the tile had been broken and raised, just that it had not been addressed.	F 253			



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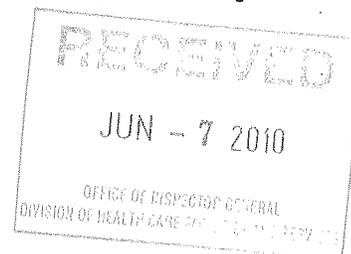
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F 253	Continued From page 3 Additionally, the garbage can should have already been emptied, as it was yesterday's garbage. The floor was supposed to be cleaned three (3) nights ago; housekeeping called and said it would be done in the evening. Review of the cleaning log for the hydrocolator revealed there was no documentation of cleaning after October 2009. Interview with the Therapy Tech on 05/13/10 at 9:05am revealed cleaning of the hydrocolator was not written down because she was never told to do so. Interview with the Housekeeping Supervisor on 05/13/10 at 9:25am revealed the floors should be mopped every night and the equipment moved to do so. The trash is to be emptied twice a day. Interview with the Central Supply Clerk on 05/13/10 at 9:35am revealed the boxes on the floor needed to be put away. The boxes contained briefs, Posey cushions and tube feeding. There is one person helping with the brief stock; however, the rest she is responsible for. The boxes have to have stickers, be tagged, and most of them go to the floor. Some go on the shelves in the back. She was off on Monday and there is no one else to help her. Interview with the Maintenance Director on 05/13/10 at 12:50pm revealed he was not aware of the cracked tiles in therapy and they should have verbally told him about it. Room rounds are made each month and repaired as needed.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		



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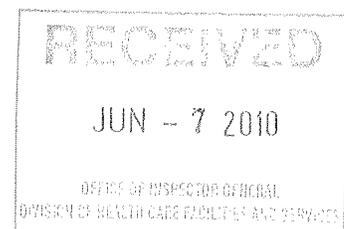
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F 274	<p>Continued From page 4</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to conduct a comprehensive assessment of a resident within fourteen (14) days after the facility determines that there has been a significant change in a resident's physical condition for one (1) of twenty-eight (28) sampled residents, (#17). Resident #17 experienced a rapid decline in physical functioning and was no longer able to ambulate, eat without assistance, declined in bowel functioning, and required the assistance of two staff for transfers.</p> <p>The findings include:</p> <p>Observation of Resident #17 on 05/12/10 at 3:40pm and on 05/13/10 at 11:00am revealed the resident in bed and receiving oxygen at two (2) liters per minute by nasal cannula. The resident's eyes were partially open; however, there was no response to verbal stimuli. The resident was</p>	F 274	<p>F274</p> <ol style="list-style-type: none"> 1) Resident #17 had a significant change assessment scheduled with an assessment reference date of 5/16/10. (See exhibit #1) 2) 100% MDS audit was completed by the Director of Nursing to identify any other potential significant change assessments in the last 3 quarters. (See exhibit #2) 3) Education on significant change regulations was given to the MDS RN Coordinators. In addition, a system was implemented in which completed MDS assessments will be cross-referenced for possible significant changes using our assessment software. No significant change will be written in the nurse summary documentation. The Director of Nursing (DON) will complete a monthly audit of completed MDS assessments to assure compliance. 		



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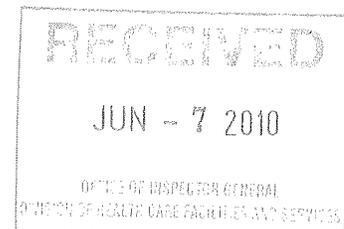
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F 274	<p>Continued From page 5</p> <p>turned by staff and the resident made no effort to assist. The resident was observed to grimace while being turned. The resident was able to slowly take a liquid supplement; however, the resident was unable to eat solid food.</p> <p>Review of the clinical record for Resident #17 revealed the resident was admitted with diagnoses of End Stage Renal Disease and Sacral Ulcer on 12/04/09. The facility completed an admission Minimum Data Set (MDS) assessment on 12/14/09 which revealed the resident had no impairment of short term or long term memory. The resident required extensive assistance of one (1) for transfer, dressing, and hygiene. The resident was ambulatory with one (1) assistant and was able to eat independently after meal set-up. The resident had an indwelling catheter and was usually continent of bowel. The resident participated in activities.</p> <p>Review of the quarterly MDS assessment completed by the facility on 02/27/10 revealed the resident now had a short term memory impairment and had been placed on palliative care on 12/30/09. The resident was no longer able to ambulate, was unable to eat without assistance of staff, had declined to total incontinence of bowel, and required two (2) assistants to transfer. In addition, the resident had sustained a fall in the past thirty (30) days.</p> <p>Interview with CNA #2 on 05/12/10 at 5:00pm, revealed Resident #17 was no longer able to perform any activities of daily living and was now total care. She stated the resident was unable to eat, turn, change position, walk or use the call light for some weeks. She indicated the resident was barely able to drink fluids. She revealed the</p>	F 274	<p>4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance.</p> <p>Completion Date: June 27, 2010</p>	



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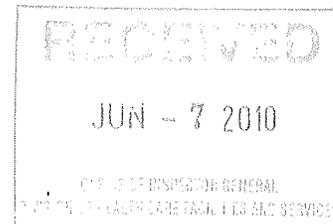
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F 274	Continued From page 6 resident has gradually gotten worse and now needs pain medication around the clock. She stated the resident still moaned when moved by staff. Interview with the Director of Nursing on 05/13/10 at 9:35am, revealed Resident #17's decline was expected and the MDS and care plan did reflect the resident's status. She stated a significant change had not occurred for Resident #17.	F 274		
F 280 SS=E	(Cross Refer F280) 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	F280 1) The care plans for Residents # 7, #12 and #17 have been updated to reflect the resident's current status (Exhibit #3) 2) A review of all other, current resident care plans will be completed. These care plans will be updated if appropriate. 3) MDS RN Coordinators received re-education on completing resident care plans (Exhibit #4). Care plans are to be reviewed and revised if appropriate upon completion of each resident MDS to ensure it reflects the resident's current status. MDS RN	



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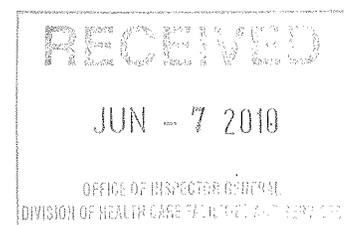
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F 280	Continued From page 7 Based on observation, record review, and interview it was determined the facility failed to review and revise the care plans for three (3) of twenty-eight (28) residents to reflect their current conditions, (#7, #12, and #17). The care plans for Residents #7, #12 and #17 were not revised to reflect the residents' current conditions regarding activities of daily living. The findings include: 1. Observation of Resident #7 on 05/11/10 at 10:25am revealed the resident in bed positioned on his/her back with bilateral bolsters, bilateral half side rails and a tube feeding infusing at 45cc per hour. The resident had a splint on the left wrist/hand. Observation on 05/11/10 at 11:10am, 2:30pm, 4:30pm and 5:30pm revealed the resident in the same position. Observation on 05/12/10 at 8:00am, 8:30am, 8:45am, 10:20am, and 10:55am revealed the resident on his/her back in bed. Observation during the skin assessment on 05/12/10 at 10:55am revealed the resident only responded by opening their eyes. No verbal communication was observed and the resident did not attempt to turn on their own without assistance from the staff. Record review of the significant change Minimum Data Set (MDS) dated 03/15/10 stated the resident as totally dependent in bed mobility, dressing, personal hygiene, bathing and eating. The care plan dated 03/15/10 stated the resident was to be fed slowly, kept in an upright position one hour after meals, set up for daily bed bath and set up for grooming. The care plan also stated the resident was to eat in the community area.	F 280	Coordinators are to update care plans as needed with any significant changes in the resident's status. Moreover, a 10% random sample of care plans will be reviewed retrospectively each month by the DON or designee. 4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance. Completion Date: June 27, 2010	



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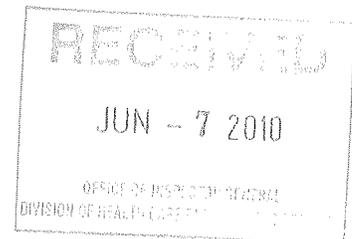
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F 280	<p>Continued From page 8</p> <p>Interview with the first floor Unit Manager on 05/13/10 at 8:40am revealed she was unaware the care plan did not match with the resident's current condition. According to the Unit Manager the resident did not assist with his/her activities of daily living and did not receive food or liquid by mouth. She stated the Minimum Data Set Coordinator was responsible for updating the care plans by receiving input from the unit nurses and by receiving a copy of new physician orders from the night shift supervisor.</p> <p>Interview with the Minimum Data Set Coordinator on 05/13/10 at 9:40am revealed she was aware the care plan did not match with the resident's current condition.</p> <p>Interview with the Director of Nursing on 05/13/10 at 9:40am revealed she was in agreement the care plan should reflect the resident's current condition.</p> <p>The facility policy revised 04/2007 states the care plan goals and objectives are reviewed and revised when there has been a significant change in the resident's condition.</p> <p>2. Review of the clinical record for Resident #12 revealed the resident was admitted with diagnoses of Congestive Heart Failure, Hypertension, and Chronic Obstructive Pulmonary Disease. The facility completed an annual Minimum Data Set (MDS) assessment on 04/16/10 which indicated the resident had a moderate impairment in the ability to make decisions regarding daily care and had behaviors of resisting care and repetitive actions. The resident required the total assistance of one to transfer, dress and manage hygiene, as well as</p>	F 280		



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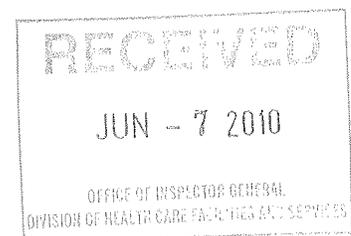
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F 280	<p>Continued From page 9</p> <p>extensive assistance of one to turn in bed and to eat. In addition, the resident was totally incontinent of bowel and bladder. There were physician orders for the resident to wear space boots while in bed.</p> <p>Review of the care plan revealed the resident was to have assistance selecting clothing and assistance to dress. The resident was to have a daily bed bath set-up and encouraged to bathe them self. The resident was to receive assistance with perineal care after incontinence and was to receive meal set-up assistance. Half side rails were to be in place and the resident was to increase independence with bed mobility and transfers. The resident was to feed them self. The resident was to stand and pivot from bed to chair. There was no mention of space boots on the care plan.</p> <p>Observation of Resident #12 on 05/11/10 at 10:20am revealed the resident was up in a Geri-chair mumbling and picking at their clothing. Both hands were contracted. The resident had oxygen at two (2) liters per minute by nasal cannula. At 11:00am, the resident was taken to the room and changed. The resident was unable to assist with the peri-care, turning in bed or transfers in and out of the chair. The resident's speech was mumbled and unclear and was not appropriate.</p> <p>Interview with Certified Nurse Aide (CNA) #3 on 05/12/10 at 5:10pm, revealed Resident #12 was not able to assist with oral care, bathing, peri-care, or grooming. She stated the resident was very confused and mumbled. She stated the resident could eat independently but could not stay on track and had to be feed most of the</p>	F 280		



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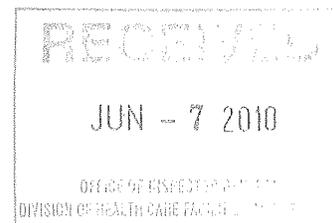
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2010
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F 280	<p>Continued From page 10</p> <p>meal. She stated the resident was unable to stand and required a mechanical lift to get from bed to chair. She stated the resident was to wear space boots while in bed to protect his/her heels.</p> <p>3. Review of the clinical record for Resident #17 revealed the resident was admitted to the facility with diagnoses of End-Stage Renal Disease, Sacral Ulcer, and Venous Stasis. The facility completed a quarterly MDS assessment on 03/01/10 which revealed the resident required extensive assistance for transfer, dressing, and hygiene. The resident had a moderate impairment in the ability to make care decisions and was incontinent of bowel and bladder.</p> <p>Review of the care plan for Resident #17 revealed the resident was to have grooming items set-up and encouraged to participate in grooming. The resident was to select clothing and assist with dressing and be set-up for bed baths and encouraged to assist. Half rails were to be used to assist the resident to increase bed mobility and the resident was to be encouraged to consume seventy-five (75) percent or more of meals. The resident was to receive indwelling catheter care daily.</p> <p>Observation of Resident #17 on 05/12/10 at 3:40pm, revealed the resident receiving care from the nurse and CNA. The resident did not respond to verbal stimulation and when turned, required two (2) persons and made no attempt to assist the staff.</p> <p>Observation of Resident #17 on 05/13/10 at 8:15am revealed the resident grimaced when turned by two staff and did not respond to any verbal stimulation.</p>	F 280			



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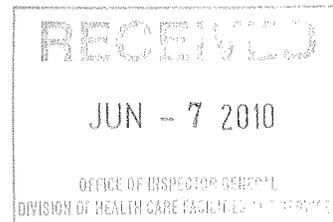
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F 280	Continued From page 11 Interview with CNA #2 on 05/12/10 at 5:00pm, revealed Resident #17 was no longer able to complete or assist with any activities of daily living. She stated the resident could not perform any part of eating and was barely able to drink fluids. She stated the resident was totally incontinent. Interview with the Director of Nursing on 05/13/10 at 9:35am, revealed the nurse responsible for care planning was on leave and that the care plans for Residents #12 and #17 should have been revised to accurately reflect the residents' current status and needs. She stated Resident #17 was actively dying.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to administer Lovenox 40mg to one (1) of the twenty-eight (28) sampled residents according to manufacturer instructions. (Resident #28) The findings include: Observation of the medication pass on 05/31/10 at 8:15am revealed Licensed Practical Nurse (LPN) #2 administering Lovenox 40 mg to Resident #28. While observing the administration of the Lovenox injection, the nurse was flicking the syringe with the head of the needle pointing	F 281	F281 1) Lovenox has been administered correctly to Resident #28. Laboratory tests completed indicate a therapeutic level of the medication. 2) The nurse giving the medication as referenced in the surveyor's report was educated on the correct medication administration technique. All staff nurses have been inserviced on the correct technique to administer Lovenox (Exhibit #5). A review of all of the residents	



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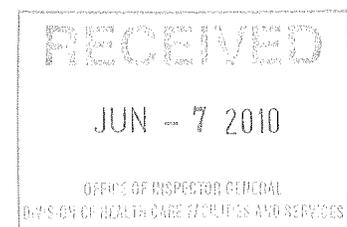
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F 281	<p>Continued From page 12</p> <p>up to relieve the air bubble in the syringe. With attempts at relieving the air bubble, LPN #2 was observed to dispel medication from the syringe three times onto the floor. When LPN #2 was successful at relieving the air bubble from the syringe she then proceeded with the steps to administer the medication subcutaneous in the abdominal area. After further discussion with the inspector, LPN #2 did not administer medication and placed the Lovenox in the sharps container.</p> <p>Interview on 05/31/10 at 8:20am with LPN #2 revealed that Lovenox was always administered with the air being expelled from the syringe and she did not know why the air should be left in the syringe.</p> <p>Interview on 05/13/10 at 1:37pm with 2nd Floor Nurse Manager revealed that nurses are not supervised by her when administering medications. She did not know to keep the air bubble in the syringe and further stated that she would not allow medication to be expelled from the syringe while relieving the air bubble.</p> <p>Interview on 05/13/10 at 10:30am with the Pharmacist Consultant revealed that the Lovenox 40mg dosage has no overage in the prefilled syringe. The Lovenox 30mg and 40mg syringe is not recommended to dispel the air bubble because this will affect the dosage if removed. The Pharmacist Consultant further stated that if he were doing the med pass with a nurse and he or she dispelled the air bubble and the medication, he would have the nurse dispose of the syringe and start all over again. He would not remove the air bubble from a 40mg syringe.</p> <p>Record Review of the Package Insert for the</p>	F 281	<p>receiving Lovenox indicates the correct administration techniques are in place.</p> <p>3) The DON or designee will conduct random, visual audits of Lovenox administration to residents on a monthly basis to ensure ongoing, correct techniques are being utilized.</p> <p>4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance.</p> <p>Completion Date: June 27, 2010</p>	



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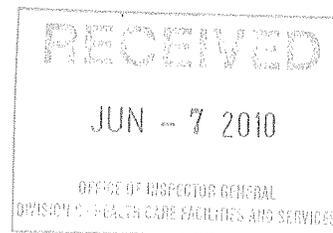
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F 281	Continued From page 13 Lovenox Injection revealed; to avoid the loss of the drug when using the 30 and 40mg prefilled syringes, do not expel the air bubble from the syringe before the injection.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide services for one (1) of twenty-eight (28) sampled residents (Resident #4) in accordance with the resident's written care plan. Resident #4 was to wear space boots while in bed; however, the resident was not observed to have these boots on during the survey. The findings include: Observation of Resident #4 on 05/11/10 at 2:30pm, 3:15pm, and 3:45pm, and on 05/12/10 at 1:00pm, revealed the resident in bed supine without any type of boots in place on his/her heels. The resident's heels were resting on the mattress. Review of Resident #4's clinical record revealed the resident was admitted with diagnoses of Adult Failure to Thrive, Dementia, and Bipolar Disease. The facility completed an annual Minimum Data Set (MDS) assessment on 03/04/10 which revealed the resident was leaving twenty-five (25)	F 282	F282 1) Resident #4's Treatment Administration Record (TAR) indicated that heel boots were to be on while in bed. This information was also contained on Resident #4 C.N.A.'s assignment sheet at the time of the surveyor review. Resident #4 has heel boots in place and shows no indication of skin break down. 2) An audit of 100% of residents with heel protectors was completed. All heel protectors were accurately included in all residents' plan of care. 3) Education was done with the C.N.A. responsible for Resident #4's care regarding the necessity and expectation to follow the C.N.A. assignment sheet and resident plan of care. In addition, a 25% sample	



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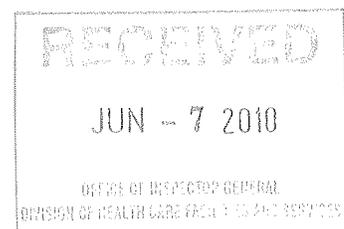
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F 282	Continued From page 14 percent or more of meals uneaten and had experienced a weight loss of nineteen (19) pounds since December 2009. The resident was on palliative care and further decline was anticipated. The Resident Assessment Protocol for Pressure revealed the resident was to wear space boots while in bed. Review of Resident #4's care plan revealed the resident had fragile skin, weight loss, and was unable to turn in bed and was not able to ambulate. The care guide for use by the Certified Nurse Aide (CNA) instructed staff to provide the space boots for the resident while in bed. Interview with CNA #3 on 05/12/10 at 3:15pm revealed the space boots were sent to the laundry several days ago. She stated there were extra boots in the laundry so there was no reason the boots should not be on the resident. Interview with Licensed Practical Nurse (LPN) #3 on 05/12/10 at 3:30pm, revealed she had been at the facility for over an hour, had not seen the resident and was not aware the space boots were not in place. She stated the CNAs were to follow the care plan unless they discussed it with her and there was a reason. She stated she would send a CNA to the laundry and obtain space boots for the resident.	F 282	of all residents wearing heel protectors will be collected each month by the DON or designee. 4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance. Completion Date: June 27, 2010		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 1) Lovenox has been administered correctly to Resident #28. Laboratory tests completed indicate a therapeutic level of the medication.		



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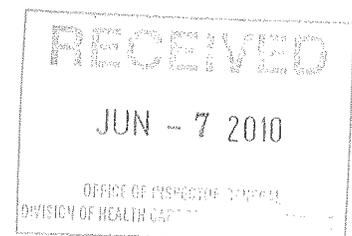
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F 309	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to administer Lovenox 40mg to one (1) of twenty-eight (28) sampled residents according to manufacturer instructions. (Resident #28) The findings include: Observation of the medication pass on 05/31/10 at 8:15am revealed Licensed Practical Nurse (LPN) #2 administering Lovenox 40mg to Resident #28. While observing the administration of the Lovenox injection, the nurse was flicking the syringe with the head of the needle pointing up to relieve the air bubble in the syringe. With attempts at relieving the air bubble, LPN #2 was observed to dispel medication from the syringe three times onto the floor. When LPN #2 was successful at relieving the air bubble from the syringe she then proceeded with the steps to administer the medication subcutaneous in the abdominal area. After further discussion with the inspector, LPN #2 did not administer the medication and placed the Lovenox in the sharps container. Interview on 05/31/10 at 8:20am with LPN #2 revealed that Lovenox was always administered with the air being expelled from the syringe and she did not know why the air should be left in the syringe. Interview on 05/13/10 at 1:37pm with the 2nd Floor Nurse Manager revealed that nurses are	F 309	2) The nurse giving the medication as referenced in the surveyor's report was educated on the correct medication administration technique. All staff nurses have been inserviced on the correct technique to administer Lovenox (Exhibit #5). A review of all of the residents receiving Lovenox indicates the correct administration techniques are in place. 3) The DON or designee will conduct random, visual audits of Lovenox administration to residents on a monthly basis to ensure ongoing, correct techniques are being utilized. 4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance. Completion Date: June 27, 2010	



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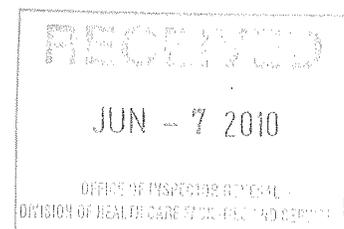
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F 309	Continued From page 16 not supervised by her when administering medications. She stated she did not know to keep the air bubble in the syringe and further stated that she would not allow medication to be expelled from the syringe while relieving an air bubble. Interview on 05/13/10 at 10:30am with the Pharmacist Consultant revealed that the Lovenox 40mg dosage has no overage in the prefilled syringe. The Lovenox 30mg and 40mg syringe is not recommended to dispel the air bubble because this will affect the dosage if removed. The Pharmacist Consultant further stated that if he were doing the med pass with a nurse and he or she dispelled the air bubble and the medication, he would have the nurse dispose of the syringe and start all over again. He would not remove the air bubble from a 40mg syringe. Record Review of the Package Insert for the Lovenox Injection revealed to avoid the loss of drug when using the 30 and 40mg prefilled syringes, do not expel the air bubble from the syringe before the injection.	F 309		
F 322 SS=E	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced	F 322	F322 1) Resident #2 and #7 have dates, hanging times and nurse initials on the enteral feeding labels. 2) All residents receiving enteral feeding were reviewed for proper enteral feeding labeling. All feeding bottles and tubes were labeled correctly.	



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F 322	<p>Continued From page 17</p> <p>by: Based on observation, record review, and interview it was determined the facility failed to minimize the risk of complications regarding gastrostomy tube feedings for two (2) of twenty-eight (28) sampled residents (Residents #7 and #2). The facility did not label the tube feeding bottles for Resident #2 and #7 with the date, time, and nurse's name/initials.</p> <p>The findings include:</p> <p>Observation on 05/12/10 at 8:00am and 05/13/10 at 8:30am of Resident #7's gastrostomy tube feeding revealed no date, time or nurse's name on the tube feeding bottle. The resident had continuous tube feedings at 45cc per hour.</p> <p>Record review for Resident #7 revealed the resident was admitted with the diagnosis of a Cerebral Vascular Accident. The physician ordered Isosource at 45cc per hour continuous with water flushes of 250cc four times per day through the gastrostomy tube.</p> <p>Interview with the first floor Unit Manager on 05/13/10 at 8:40am revealed the tube feeding bottle should be labeled when a new bottle is started with date, time and nurse's name.</p> <p>Observation of Resident #2 on 05/11/10 at 10:40am revealed the gastrostomy tube feeding bottle was not labeled with date, time or nurse's name that started the tube feeding.</p> <p>Record review of Resident #2 revealed the resident was admitted with the diagnosis of Aphasia (difficulty swallowing). The resident had an order for Glucerna 1.2 to infuse at 75cc per</p>	F 322	<p>3) The facility's policy and procedure on administering enteral feedings was revised to include the dating of the bottle (Exhibit #6). An inservice was given to all staff nurses on the revised policy and procedure (Exhibit #7). In addition, an audit of 100% of residents receiving enteral feedings will be conducted minimally twice per month.</p> <p>4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance.</p> <p>Completion Date: June 27, 2010</p>	



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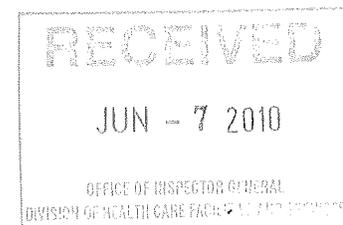
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F 322	Continued From page 18 hour via gastrostomy tube with water flushes 250cc four times a day. Interview with Licensed Practical Nurse (LPN) #5 on 05/12/10 at 11:55am revealed he was training a new employee and she was the person who hung the tube feeding bottle on Resident #2. He admitted the bottle should be labeled with the resident's name, date, time and staff initials who hung the bottle of tube feeding. Interview with the Director of Nursing (DON) on 05/12/10 at 11:00am revealed she expected the tube feeding bottle to be labeled with the date, time, and staff initials at the very least. Continued interview with the DON on 05/13/10 at 2:30pm revealed it is nursing practice to label tube feeding bottles. She stated the facility had no policy and procedure regarding labeling of tube feeding bottles.	F 322		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to implement physician ordered therapeutic diets and follow the menus for those diets as planned by the dietician for two (2) of twenty-eight (28) sampled residents. (Residents #5 and #19)	F 363	F363 1) Facility menus are developed, reviewed and approved by registered dietitians in accordance to recommended dietary guidelines for nutrition and allowances. Resident #5 and #19 received the appropriate mechanically-altered meals immediately. Facility implemented an enhanced system of highlighting mechanically-altered diet instructions on the resident's tray card.	



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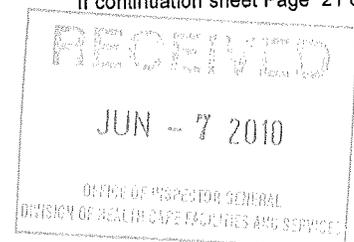
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 363	<p>Continued From page 19</p> <p>The findings include:</p> <p>Observation of Resident #19 on 05/11/10 at 5:10pm revealed the resident was served corn and regular meat loaf instead of carrots and ground meat loaf as indicated by the therapeutic menu for a mechanical soft diet. The resident coughed with each bite of corn until after inquiry by the surveyor resulted in the staff obtaining carrots for the resident. The resident was observed not to have teeth and no dentures were in place.</p> <p>Review of the clinical record for Resident #19 revealed the resident had a chewing problem and a diagnosis of Dysphagia. The facility completed an annual Minimum Data Set (MDS) assessment on 11/18/09 which revealed the resident had a chewing problem and wore dentures. The quarterly MDS assessment dated 02/18/10 revealed the resident required supervision while eating.</p> <p>Interview with CNA #3 on 05/12/10 at 5:00pm, revealed the resident would not wear his/her dentures and therefore the resident required soft food that could be easily chewed.</p> <p>Observation of Resident #5 during lunch on 05/11/10 at 11:50am revealed the resident was served a regular salad which consisted of regular sized portioned lettuce, wedged tomatoes, cheese and Thousand Island dressing. Continued observation on 05/12/10 at 5:20pm revealed Resident #5 received a regular turkey sandwich.</p>	F 363	<p>2) A review of all residents with a mechanically-altered diet was completed to ensure accuracy of physician orders, tray card instructions, C.N.A. assignment sheets and resident's individualized plan of care. Changes to a resident's mechanically-altered diet were initiated if indicated as a result of this review.</p> <p>3) Food service staff were re-educated on serving mechanically-altered meals. All staff nurses and C.N.A.s will be re-educated on serving mechanically-altered meals to ensure the resident receives the appropriate meal in accordance with the individual's dietary orders. In addition, the Certified Dietary Manager (CDM) will complete a weekly audit of 15 resident meals to ensure the appropriate mechanically-altered meal is prepared and served as ordered.</p>	



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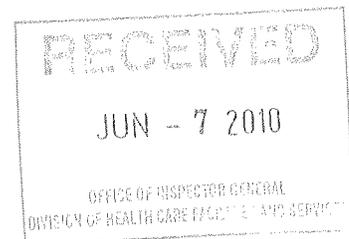
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F 363	Continued From page 20 Record review revealed that Resident #5 had chewing issues related to refusing to wear dentures. The resident was placed on a mechanical soft diet per Medical Doctors orders. Interview with Licensed Practical Nurse (LPN) #1 on 05/11/10 at 12:10pm revealed that residents receiving mechanical soft diets usually receive a regular sized salad with meal. Interview with Assistant Dietary Manager (ADM.) on 05/13/10 at 1:00pm revealed that residents who receive mechanical soft diets should not receive regular salads. The residents were not receiving the correct therapeutic diet compared to the therapeutic meal. The lettuce should be shredded as well as the tomatoes. She stated that Resident #5 should not be served a regular turkey sandwich related to mechanical soft diet and further stated that she was unaware that these food items were given. Interview with the Dietician on 05/13/10 at 10:15am revealed the residents receiving mechanical soft diets should receive finely chopped lettuce and tomatoes when receiving salads. Residents on a therapeutic diet should not receive a whole turkey sandwich. The Dietician was not aware that staff were not using the therapeutic dietary plan at the tray line service. She further stated that residents who receive mechanical soft diets are at risk for aspiration if offered wedged tomatoes.	F 363	4) The weekly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance. Completion Date: June 27, 2010	
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs.	F 365		



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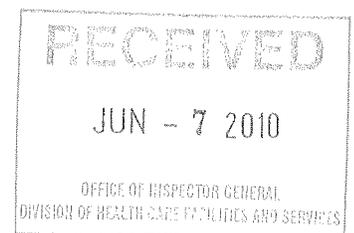
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F 365	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide a diet consistent with Medical Doctors (MD) orders as evidenced by two (2) of twenty-eight (28) sampled residents. Residents #5 and #19 received food that was not mechanical soft in texture at meal times. The findings include: Observation of Resident #5 during lunch on 05/11/10 at 11:50am revealed the resident was served a regular salad which consisted of regular sized portioned lettuce, wedged tomatoes, cheese and Thousand Island dressing. Continued observation on 05/12/10 at 5:20pm revealed Resident #5 was served a regular turkey sandwich. Record review of the Minimum Data Set (MDS) for Resident #5 revealed the resident had chewing problems and no dentures. Record review of the physician orders for Resident #5 revealed the resident was to receive a mechanical soft diet as of May 2010. Interview with Licensed Practical Nurse (LPN) #1 on 05/11/10 at 12:10pm revealed residents who receive mechanical soft diets usually receive a regular salad. Interview with the Director of Nursing (DON) on 05/13/10 at 9:57am revealed that the nurses on the units supervise the dining rooms, but there is no specific nurse actually assigned the task. The	F 365	F365 1) Resident #5 and #19 received the appropriate mechanically-altered meals immediately. Facility implemented an enhanced system of highlighting mechanically-altered diet instructions on the resident's tray card. 2) A review of all residents with a mechanically-altered diet was completed to ensure accuracy of physician orders, tray card instructions, C.N.A. assignment sheets and resident's individualized plan of care. Changes to a resident's mechanically-altered diet were initiated if indicated as a result of this review. 3) Food service staff were re-educated on serving mechanically-altered meals. All staff nurses and C.N.A.s will be re-educated on serving mechanically-altered meals to ensure the resident receives the appropriate meal in	



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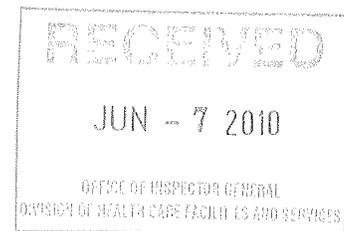
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F 365	<p>Continued From page 22</p> <p>nurses observations include the environment, the tray carts to make sure residents receive the right meal and to make sure Certified Nursing Assistants (CNA) are delivering trays correctly.</p> <p>Interview with the Dietician on 05/13/10 at 10:15am revealed the residents receiving mechanical soft diets should receive finally chopped lettuce and tomatoes when receiving salads. Residents on a therapeutic diet should not receive a whole turkey sandwich. The Dietician was not aware that staff were not using the therapeutic dietary plan at the tray line service. She further stated that residents who receive mechanical soft diets are at risk for aspiration if offered wedged tomatoes.</p> <p>Observation of Resident #19 on 05/11/10 at 5:10pm revealed the resident was served corn and regular meat loaf instead of carrots and ground meat loaf as indicated by the therapeutic menu for a mechanical soft diet. The resident coughed with each bite of corn until after inquiry by the surveyor resulted in the staff obtaining carrots for the resident. The resident was observed not to have teeth and no dentures were in place.</p> <p>Review of the clinical record for Resident #19 revealed the resident had a chewing problem and a diagnosis of Dysphagia. The facility completed an annual Minimum Data Set (MDS) assessment on 11/18/09 which revealed the resident had a chewing problem and wore dentures. The quarterly MDS assessment dated 02/18/10 revealed the resident required supervision while eating.</p> <p>Interview with CNA #3 on 05/12/10 at 5:00pm</p>	F 365	<p>accordance with the individual's dietary orders. In addition, the Certified Dietary Manager (CDM) will complete a weekly audit of 15 resident meals to ensure the appropriate mechanically-altered meal is prepared and served as ordered.</p> <p>4) The weekly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance.</p> <p>Completion Date: June 27, 2010</p>		



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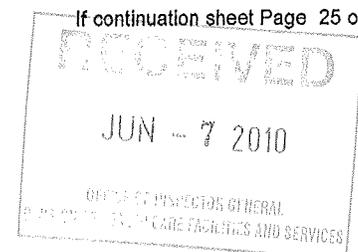
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F 365	Continued From page 23 revealed Resident #19 would not wear dentures and therefore the resident required soft food that could be easily chewed.	F 365		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. The dietary staff failed to ensure food preparation and storage areas remained clean and free of debris. In addition, there were opened foods undated and unlabeled in the refrigerator and a coat hanger was being used to dislodge clumps of food from the deep fryer oil drain. The findings include: Observation of the kitchen on 05/11/10 at 7:45am revealed the wall behind the three (3) compartment sink was spotted with brown and black substances. The oven had a heavy build-up of food particles, a tray cart had white dried drips and spots on the inside and there were three (3) glasses of juice and twelve (12)	F 371	F371 1) All items noted to be non-compliant in the surveyor's report were cleaned or discarded. 2) The CDM conducted an audit of all equipment in the kitchen to assess any additional cleaning needs. In addition, an audit was conducted in all of the kitchen refrigerators and freezers to ensure no unlabeled items were present. Cleaning was completed as indicated. 3) The Registered Dietitian or CDM will conduct sanitation audits twice monthly. In addition, the CDM is revising the kitchen cleaning schedules to ensure enhanced follow-up and completion of these duties as directed.	



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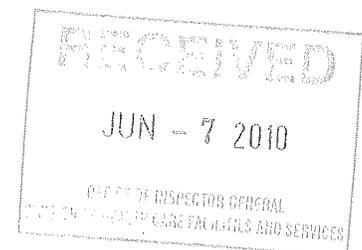
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F 371	Continued From page 24 sandwiches in the refrigerator with hard bread that was undated. Observation on 05/13/10 at 1:15pm revealed surfaces of the steamer, deep fryer, refrigerators, plate warmer, ovens, toaster, can opener and utility carts were smeared, had food particles and dirty corners, knobs, and handles. A bent coat hanger was found wrapped around a shelf and was being used to unclog the deep fryer drain when food particles were plugging the drain. Interview with the Assistant Dietary Manager on 05/13/10 at 1:10pm, revealed there was a cleaning schedule in the kitchen; however, she had no information regarding how the schedule was supervised by the Dietary Manager. Interview with the Dietician on 05/12/10 at 9:35am, revealed she completed a sanitation audit in the kitchen monthly and a follow-up review on her next visit. She stated problems were addressed immediately. Review of the facility policy for Sanitation, undated, revealed cleaning schedules were established and assigned to employees on a daily, weekly, and monthly basis. Formal sanitation inspections would occur on a frequent basis and informal inspections would be performed daily.	F 371	4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance. Completion Date: June 27, 2010	
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456		



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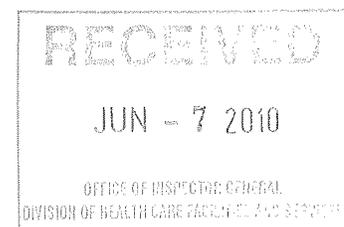
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F 456	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain all patient care equipment in safe operating condition. Nine (9) residents were observed to have wheelchairs with arm pads that had worn, cracked, and/or torn vinyl covers. One (1) resident used a wheelchair with an arm rest completely missing. The findings include: Observation of residents in the facility on 05/13/10 revealed the following residents seated in wheelchairs with damaged arm rests: · At 9:25am the resident in Room 108-A was seen in a wheelchair with the vinyl of the left arm rest cracked and rough to the touch. · At 10:00am the residents in Room 228 and 116B were observed seated in wheelchairs with both arm rest pads cracked and torn. · At 10:05am the resident in Room 222 (Resident #8) was observed sitting in a wheelchair with the right arm rest completely missing. Interview at this time with this resident revealed the chair had been in this condition since it was assigned to the resident for "most of a year". · At 10:30am the resident in Room 226-B was observed seated in a wheelchair with both arm rest pads worn at the ends and padding exposed. · At 10:35am the resident in Room 225-B was observed sitting in a wheelchair with the right arm rest pad cracked and rough. · At 10:40am the resident in Room 202-B was observed seated in a wheelchair with both arm rest pads cracked and torn. The resident stated the chair was issued to him/her the previous week	F 456	F456 1) All wheelchairs identified in the surveyor's report had any worn or missing arm pads replaced. 2) The Assistant Director of Nursing (ADON) completed an assessment of all wheelchairs currently being used to assess any further needs of repair or replacement of arm pads. The Therapy Director or designee completed an assessment of all wheelchairs that may be potentially used by residents to assess any further needs of repair or replacement of arm pads. Wheelchair arms will be repaired or replaced as indicated as a result of the audit. 3) The Director of Maintenance or designee will conduct a random audit of 20 wheelchairs each month to ensure compliance. In addition, facility management,		



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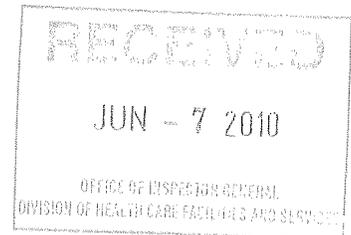
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F 456	<p>Continued From page 26</p> <p>on admission and was not comfortable.</p> <ul style="list-style-type: none"> At 10:45am the resident in Room 209 (Resident #11) was observed sitting in a bariatric wheelchair with both arm rests cracked and rough. At 10:50am the resident in Room 230-A was seen seated in a wheelchair with the vinyl completely worn away and inner padding exposed on both arm rests. At 10:55am the resident in Room 121-A was observed sitting in a wheelchair with the vinyl on both arm rests cracked. At 11:10am the resident in Room 132-B was seen sitting in a wheelchair with the covers of the arm rests cracked. <p>Interview on 05/13/10 at 8:40am with the Therapy Manager revealed that the therapy department had replacement parts for the wheelchairs. Either therapy staff or maintenance staff changed arm rests on wheelchairs before they were issued/assigned to residents. The manager stated no faulty arm rests should be observed on chairs issued to residents in the facility. She further stated it was the responsibility of the therapy staff to identify chairs that needed to be repaired.</p> <p>Interview on 05/13/10 at 12:50pm with the Maintenance Director revealed he was not aware of wheelchairs in need of repair in the facility. He said the therapy department was responsible for ordering replacement parts (anti-tippers, anti-roll devices and arm rests) and a therapist who recently left the facility normally replaced the foot rests and arm rests. He stated replacement of arm rests required removing two screws only. He said that torn arm rest pads could potentially cause skin tears on the arms of thin-skinned</p>	F 456	<p>therapy staff, staff nurses and C.N.A.s will receive education on safe equipment conditions and maintenance request reporting system.</p> <p>4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance.</p> <p>Completion Date: June 27, 2010</p>	



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F 456	Continued From page 27 residents.	F 456			



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K 000	INITIAL COMMENTS	K 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 05/26/10, it was determined the facility failed to ensure decorations used in the facility were flame-retardant as required by NFPA 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. The findings include: Observations during the Life Safety Code tour, conducted on 05/26/10, at 2:15pm, revealed doors throughout the facility were decorated with wreaths. Stuffed animals were noted to be throughout the facility and there was no documentation to indicate the stuffed animals had been sprayed with a flame-retardant. An Interview conducted with the Maintenance Director, on 05/26/10 at 2:30pm, revealed the wreaths had been put on the doors by family members, the facility did not have any	K 073	K073 1) Stuffed animals and door wreaths noted by the surveyor will be sprayed with a flame-retardant. 2) An audit will be completed to identify any other stuffed animals or door wreaths that are in need of a flame-retardant spray. Items will be sprayed with a flame-retardant as indicated with this audit. 3) To ensure non-recurrence, the facility will implement a new policy in which stuffed animals and door wreaths will be sprayed with a flame-retardant by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

x *Raynel A. [Signature]*

x Executive Director

x 6/17/10

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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K 073	Continued From page 1	K 073	maintenance or	
K 135 SS=D	documentation that would indicate the flame rating of the wreaths on the doors or documentation indicating the stuffed animals had been treated. NFFA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1. This STANDARD is not met as evidenced by: Based on observation and staff interviews conducted on 05/26/10, it was determined the facility failed to properly store flammable and combustible liquids. The findings include: An observation during the Life Safety Code inspection on 05/26/10 at 10:45am revealed one can of wood finish, four cans of stain steel cleaner and one can of 10W40. These items were stored in a metal cabinet and not a flammable proof cabinet. The label on the above items stated combustible, danger, extremely flammable. All flammable materials shall be stored in a flammable proof cabinet.	K 135	environmental services. In addition, a letter will be sent to all residents and/or responsible parties informing them of the new policy (Exhibit #1). Department management, CNAs, staff nurses, maintenance personnel, environmental services staff and activity staff will be educated on facility's policy. The environmental services director or designee will conduct a random audit of 20 resident rooms and all resident doors monthly to ensure compliance. Any non-compliant stuffed animals or door wreaths will be removed until the said item(s) is sprayed with a flame-retardant. 4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance. Date of Completion: July 10, 2010	

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: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/26/2010
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 135	Continued From page 2 An interview conducted with the Maintenance Director on 05/26/10 at 11:00am, revealed the above items would be stored in the flammable cabinet in the building next door until the facility could purchase a flammable proof cabinet for the main building.	K 135	K135 1) Items noted in the surveyor's report were moved to the cabinet referenced in the report. 2) An audit will be conducted by the Maintenance Director of the facility's storage and maintenance rooms to ensure no flammable or combustible liquids are improperly stored. 3) A flammable proof cabinet was purchased and placed in the facility. The maintenance director will do a monthly audit of the maintenance rooms to ensure proper storage of materials. 4) The monthly audit findings will be reviewed monthly or as directed by the facility Quality Assurance (QA) Committee to ensure ongoing compliance. Date of Completion: July 10, 2010	