

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

RECEIVED

APR - 8 2013

PRINTED: 03/28/2013
FORM APPROVED
OMB NO. 0938-0391
(X3) DATE SURVEY COMPLETED
03/14/2013

Division of Health Care
Regulation and Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42066	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	<u>Disclaimer for Plan of Correction</u>	
F 263 SS=E	<p>A standard health survey was conducted on 03/12-14/13. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observation during the environmental tour on 03/14/13, beginning at 10:30 AM, revealed the outside corner of the desk located at the nurses' station had jagged edges and a nail was exposed and protruded from the wall approximately one-half inch; one resident room had loose floor tiles; and three hallway areas had broken and chipped tiles.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Repair Requisition" dated October 2008 revealed it was the responsibility of the employee identifying a needed repair to complete a "Repair Requisition." The policy revealed the Director of Maintenance would pick up any repair requisitions each morning to make the needed repairs. When the repair was completed a copy of the repair requisition would then be forwarded to the</p>	F 263	<p>Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Kuttawa of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Kuttawa files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.</p> <p><u>F 253</u></p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lindy Bouton TITLE: Administrator (X6) DATE: 4-8-13

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

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F 253	<p>Continued From page 1 Administrator.</p> <p>Observation during the environmental tour beginning on 03/14/13, at 10:30 AM, revealed:</p> <ul style="list-style-type: none"> -The outside corner of the desk at the nurses' station on the 100/200 Unit of the facility was observed to have jagged edges and a nail was exposed and protruded from the wall approximately one-half inch. -Resident room 101 was observed to have loose tile on the floor at the corner near the door. -The hallway tile between resident rooms 107 and 109 was observed to be chipped and broken. -The hallway tile between resident rooms 101 and 102 was observed to be chipped and broken. -The hallway tile beside the entrance to the dining room was observed to be chipped and broken. <p>An interview conducted with the Maintenance Director on 03/14/13, at 10:46 AM, revealed he was responsible to do a weekly round to identify environmental concerns. The Maintenance Supervisor stated that any areas that were identified by the staff to be in need of repair were required to be placed on a work repair requisition sheet, and the staff was then to place the requisition in a box located outside of the Maintenance Director's office. The Maintenance Director revealed he had not observed the identified areas in need of repair and he had not received any work orders from staff.</p> <p>An interview conducted with the Administrator on</p>	F 253	<p><u>Corrective Actions for Targeted Areas</u></p> <p>On 3/14/13, the Director of Maintenance repaired the jagged edges and the exposed nail at the 100/200 unit desk.</p> <p>The flooring of room 101, hallway between rooms 107 and 109, the hallway between rooms 101 and 102, and beside the entrance to the dining room are being repaired by Coal Field Flooring Company. Work is scheduled to begin 4/11/13. Administrator obtained a written agreement from Coal Field Flooring Company on 4/4/13. Work will be completed by 4/24/13.</p> <p><u>Identification of Other Areas with Potential to be Affected</u></p> <p>The Director of Maintenance has audited the facility for other areas affected. The audit was completed on 3/28/13 and no other areas were found to be affected.</p> <p><u>Systematic Changes</u></p> <p>The Maintenance Director was in-serviced on 3/15/13 by the Administrator regarding the requirement for maintaining a facility that is sanitary, orderly and has a comfortable interior.</p> <p><u>Monitoring</u></p> <p>Weekly audits will be conducted by the Director of Maintenance for three months, then quarterly. The Director of</p>	

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F 253	Continued From page 2 03/14/13, at 10:50 AM, revealed any staff member who observed a maintenance issue was required to complete a repair requisition and submit it to the Maintenance Director. The Administrator stated she had not observed and had not been made aware of the identified areas in need of repairs.	F 253	Maintenance will report results of these audits to the monthly Performance Improvement Committee for review and determination of ongoing compliance. This Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.	
F 323 SS=D	403.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure supervision was provided to prevent potential accident hazards for one unsampled resident (Resident B). Medications were observed to be left unattended in Resident B's room during the facility tour on 03/12/13. The findings include: Review of the Medication Administration policy (dated June 2009) revealed facility staff was responsible to push the medication cart to the resident's area and to check for correct identification of the resident. The policy noted the staff would be responsible to administer the	F 323	<u>F 323</u> Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> On 3/12/13, Resident B was immediately given the medication in the cup and the three pills found in the plastic dish at bedside. The charge nurse assisting with the survey tour observed the resident swallow the medications.	4/28/13

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F 323	Continued From page 3 medications to the residents and to observe the resident swallow the medications. The policy stated, "Never leave a drug in a resident's room." A general tour was conducted of the 300 Hall on 03/12/13, at 9:00 AM (EDST) with facility staff. During the tour, Resident B was observed sitting in a motorized wheelchair beside the resident's bed at 9:16 AM. A partially consumed breakfast tray was observed on the resident's overbed table. Resident B was observed to be holding a plastic medication cup containing six tablets and three additional tablets were also observed to be in a plastic dish on the resident's table. Resident B stated, "These are my medications the nurse left for me to take a few minutes ago." Interview conducted with Registered Nurse (RN) #1 on 03/13/13, at 1:50 PM, revealed the RN was the medication nurse for the 300 Hall on 03/12/13 for the morning medication pass. RN #1 confirmed she had delivered the medications to Resident B on 03/12/13 and left the room without observing the resident take the medications. RN #1 stated she had been trained to stay with the resident to observe the resident swallow the medications. Interview conducted with the Interim Director of Nurses (DON) on 03/14/13, at 11:10 AM, revealed the nurses had been trained to supervise the residents during medication administration. The DON confirmed the nurses should never leave medications at a resident's bedside and should observe the resident swallow the medication and take the medication cup with them when they left the room.	F 323	<u>Identification of Other Residents with Potential to be Affected</u> A resident room audit was conducted on 3/12/13 by the Assistant Director of Nursing to ensure that no other medications were left at bedside. None were found. <u>Systematic Changes</u> On 3/12/13, the Interim Director of Nursing and Assistant Director of Nursing re-educated licensed nurses on the policy and procedure for medications administration. The nurse involved in leaving medications with Resident B received disciplinary actions on 3/18/13. A mandatory in-service was conducted by the Assistant Director of Nursing for licensed staff on 4/5/13, with emphasis on policy/procedure for medication administration. <u>Monitoring</u> Resident room audits will be completed daily for two weeks by the Assistant Director of Nursing or RN Supervisor to ensure medications are not left at bedside, then checked weekly for three months. Results of these audits will be presented to the monthly Performance Improvement Committee meeting by the DON or ADON for review and determination of ongoing compliance. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director,	
F 366	483.35(d)(4) SUBSTITUTES OF SIMILAR	F 366		

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F 366 3S=D	<p>Continued From page 4 NUTRITIVE VALUE</p> <p>Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to honor food dislikes for two of fifteen sampled residents (Residents #3 and #9) during the noon meal service on 03/12/13.</p> <p>The findings include:</p> <p>Review of the facility policy, "Resident Rights-Dietary Department," no date given, revealed ...3. Reasonable accommodations should be made by the Dietary Department to those residents with food preferences. A food preference list should be obtained during the Initial Nutritional Screen by the Dietary Manager or Dietary Technician/Clinical Manager...</p> <p>1. Observation of the noon meal on 02/12/13, revealed Resident #3's tray card had dislikes displayed, including green beans. Observation of resident #3's tray on 03/12/13 at 12:05 PM, revealed green beans had been served on the resident's tray.</p> <p>Interview with Resident #3 on 03/12/13 at 12:05 PM, revealed a strong dislike for the green beans, however, the resident stated he/she tried to eat them if received on the tray.</p>	F 366	<p>Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.</p> <p><u>F 366</u></p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Residents</u></p> <p>Resident #3 was provided green peas as an alternate to green beans for lunch on 3/12/13 by the Dietary Manager. Resident #9 was provided mashed potatoes as an alternate to rice for lunch on 3/12/13 by the Dietary Manager. Both residents were satisfied and consumed the alternates that were provided.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>The Dietary Manager observed breakfast, lunch and supper trays on 3/13/13 to ensure that food dislikes were not being served.</p>	4/28/13

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F 366	<p>Continued From page 5</p> <p>Interview with the Dietary Manager on 03/13/13 at 4:15 PM, revealed Resident #3's dislikes were overlooked, and the resident should have gotten peas instead of the green beans.</p> <p>2. Observation of the noon meal on 02/12/13 at 12:00 PM, also revealed Resident #9's tray card to have dislikes displayed, including rice. Observation of Resident #9's tray revealed a full serving of rice had been left uneaten on the resident's plate.</p> <p>Interview with Resident #9 on 03/12/13 at 12:10 PM, revealed he/she did not like rice, but continued to get the rice whenever it was served.</p> <p>Interview with the Dietary Manager (DM) on 03/13/13 at 4:15 PM, revealed Resident #9's dislikes were also overlooked, and the resident should have gotten mashed potatoes instead of the rice.</p> <p>Interview with the Dietary Aide on 03/14/13 at 9:05 AM, revealed she was responsible for checking the tray cards for dislikes, and revealed they should be highlighted when serving those items. The Dietary Aide stated since they were running behind on 03/12/13, the Dietary Manager highlighted the dislikes for them.</p> <p>Interview with the Dietary Manager on 03/13/13 at 4:15 PM, revealed dislikes should be highlighted on the dietary tray cards and she stated she monitors the halls daily, and checks the tray cards for dislikes. However, the DM stated there was no documentation that monitoring was being done. The Dietary Manager stated she highlighted the dislikes for the noon meal on</p>	F 366	<p><u>Systematic Changes</u></p> <p>The Dietary Manager reviewed tray cards on 3/13/13 and highlighted the food dislikes. An in-service with Dietary staff was conducted by the Dietary Manager on 3/13/13, with emphasis on highlighting dislikes on tray cards, and taking the time to read tray cards thoroughly. The Registered Dietician will conduct an in-service on 4/10/13 regarding honoring residents' food dislikes.</p> <p><u>Monitoring</u></p> <p>The Dietary Manager or Cook will monitor the tray line daily Monday through Friday, and the Cook will monitor the tray line on weekends, for a period of three months to ensure staff is honoring dislikes. The Dietary Manager will complete audits of these findings and present them to the Performance Improvement Committee for a period of three months to ensure ongoing compliance. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.</p>	4/28/13

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F 366	Continued From page 6 03/12/13, but may not have highlighted the dietary tray cards for Residents #3 and #9. Interview with Certified Nurse Aide (CNA) #3 on 03/14/13 at 9:30 AM, revealed she had been trained to look at tray cards for dislikes, which were highlighted when dislikes were served. The CNA also stated dislikes were listed on the CNA care plans. Interview with the Administrator on 03/14/13 at 10:15 AM, revealed Administrative Staff monitors the tray cards at mealtimes, as well as Dietary and Nursing Staff. The Administrator also revealed the Dietary Manager and Dietitian conduct periodic audits and the kitchen staff should be checking the dislikes list for any residents who do not like certain foods.	F 366			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure a therapeutic diet was provided as ordered for one of fifteen sampled residents (Resident #5). Resident #5's physician had prescribed a Consistent Carbohydrate pureed diet with thin liquids for the resident. However, observations conducted during the lunch meal on 03/12/13 and the breakfast meal on 03/13/13 revealed the resident did not receive pureed foods as ordered by the physician.	F 367	<u>F 367</u> Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> On 3/13/13, Resident #5's physician was contacted by the Assistant Director of Nursing, and received an order to discontinue the puree consistency diet and to serve regular textured food. Resident #5:		

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F 307	<p>Continued From page 7</p> <p>The findings include:</p> <p>A review of the facility's "Therapeutic Diet" policy (dated September 2011) revealed therapeutic diets would be planned, prepared, and served with supervision or consultation from a Dietitian. The policy noted the Nursing Department was responsible to submit written diet orders to the Dietary Department. The policy verified the diet order should correspond with the physician's orders.</p> <p>Review of the medical record revealed the facility readmitted Resident #5 on 01/17/13 from the hospital with diagnoses including Acute Renal Failure, Gastroesophageal Reflux, Diabetes Mellitus, and Senile Dementia. Review of the readmission orders revealed the physician prescribed a Consistent Carbohydrate diet with pureed consistency and thin liquids for Resident #5.</p> <p>Review of the significant change comprehensive MDS assessment dated 01/23/13, revealed the facility assessed Resident #5 as receiving a therapeutic diet, and required extensive assistance with eating. The resident was further assessed to have no problems with swallowing or chewing. The assessment also revealed Resident #5 was not assessed to be edentulous or to have broken natural teeth or dentures.</p> <p>Observation conducted during the noon meal on 03/12/13, at 1:35 PM (EDST) revealed the resident was served a lunch tray in his/her room. The tray was observed to contain chopped steak with gravy, rice, and green beans. The resident</p>	F 307	<p>is currently receiving a Consistent Carbohydrate diet, regular texture and thin liquids. Resident #5 has tolerated the regular consistency without difficulty.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>A facility chart audit was conducted on 3/13/13 by the Interim Director of Nursing, Assistant Director of Nursing, and Dietary Manager to check MD orders with current residents to ensure that therapeutic diets are being served. No other residents were found to be affected.</p> <p><u>Systematic Changes</u></p> <p>On 3/14/13, the Dietary Manager in-service the Dietary staff to address that no tray will be sent to a resident until the Dietary Department receives the status report form from Nursing. Another in-service will be conducted by the Registered Dietician on 4/10/13 on the importance of serving the proper consistency that has been order by the MD. The Dietary Manager/Cook will check status report forms with MD orders upon resident admissions/readmissions to ensure accuracy of diet.</p> <p><u>Monitoring</u></p> <p>The Dietary Manager or Cook will audit dietary orders on any resident admissions/readmissions within 24 hours of</p>		

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F 367	<p>Continued From page 8</p> <p>was observed to eat the foods without difficulty. On 03/13/13, at 8:50 AM (EDST), Resident #5 was observed to be eating breakfast in his/her room. The breakfast tray consisted of biscuit with gravy, scrambled eggs, sausage patty, and yogurt. The food items were observed to be of regular consistency. Resident #5 was again observed to eat the foods without difficulty.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #1 on 03/13/13, at 3:50 PM revealed she readmitted Resident #5 to the facility on 01/17/13. LPN #1 stated the prescribed diet order was to be transcribed onto a "status report" form and given to the Dietary Department. LPN #1 stated she could not recall if she completed the status report for the diet order for Resident #5 when the resident was readmitted to the facility on 01/17/13. LPN #1 confirmed the resident had not been receiving a pureed diet since being readmitted to the facility.</p> <p>Interview conducted with the Speech Therapist (ST) on 03/13/13, at 9:00 AM revealed Resident #5 had experienced weight loss after readmission to the facility and she had conducted an assessment of the resident. The ST stated that during the screening and treatment provided she had not identified Resident #5 to have dysphagia (difficulty swallowing). The ST stated she checked the resident's diet order during the screening; however, she did not realize the resident was prescribed a pureed diet.</p> <p>Interview conducted with the Dietary Manager (DM) on 03/14/13, at 8:50 AM, confirmed the nurses were responsible to notify the Dietary Department of diet orders by completing the</p>	F 367	<p>entrance into the facility. The audits will be completed daily for one month, then weekly for three months, to ensure ongoing compliance. Results of the audits will be reported to the Performance Improvement Committee monthly by the Dietary Manager. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.</p>	4/28/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 367	Continued From page 9 "status report" form. The DM stated she did not receive the new diet order for Resident #5. The DM stated the resident was receiving a Consistent Carbohydrate diet of regular consistency prior to going to the hospital and she had continued to follow that diet order after the resident's readmission to the facility. The DM further stated she routinely checked the diet orders when a resident was readmitted; however, she could not recall checking the orders for Resident #5.	F 367			
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 facility policy review, the facility failed to ensure food was distributed under sanitary conditions to residents in the dining room during the lunch meal on 03/12/13 and the breakfast meal on 03/13/13. Uncovered food items were observed to be obtained from the kitchen meal cart and transported several feet to the residents and, as a result, the food items were exposed to any potential airborne bacteria or contaminants.	F 371	F 371 Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> During lunch in the dining room on 3/14/13, the remaining trays to be served were covered and served by nursing staff. <u>Identification of Other Residents with Potential to be Affected</u> Current residents who receive their meals in the dining room had the potential to be affected.		

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42056		
(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 371	<p>Continued From page 10</p> <p>The findings include:</p> <p>A review of the facility's Tray Line Setup and Service policy (dated October 2008) revealed "the main plate" was to be served from the steam table and "covered."</p> <p>1. Observation conducted during the noon meal on 03/12/13, at 1:12 PM revealed 17 residents were seated in the dining room. Facility staff was observed to transport and deliver food trays with uncovered food items from an open cart to the 17 residents. The food cart was transported from 14 feet to 44 feet throughout the dining room with the uncovered foods. The trays were observed to pass by several residents as well as other staff while being transported and then delivered to the residents in the dining room.</p> <p>2. Observation of the breakfast meal service on 03/13/13, beginning at 8:25 AM revealed the Dietary Manager transported 18 uncovered meal trays on a serving cart approximately 5 feet from the kitchen to the dining room. In addition, the uncovered meal trays were delivered to 18 residents in the dining room that were sitting approximately 5 feet to 50 feet from the serving cart.</p> <p>An interview conducted with the Dietary Manager on 03/13/13, at 8:50 AM, revealed the facility never covered meal trays that were delivered to residents in the dining room. The Dietary Manager stated the only trays the facility covered were the ones that were delivered to the floors. The Dietary Manager stated she was not aware of the facility policy related to covering trays for residents in the dining room.</p>	F 371	<p><u>Systematic Changes</u></p> <p>An in-service with Dietary staff was conducted by the Dietary Manager on 3/14/13 regarding meal trays leaving the kitchen are to be covered, including for residents being served in the dining room.</p> <p><u>Monitoring</u></p> <p>The Dietary Manager or Cook will audit meal trays that go to the dining room daily for two weeks, and then weekly for four weeks to ensure trays are covered. Results of these audits will be reported by the Dietary Manager to the Performance Improvement Committee, which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.</p>	4/28/13	

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

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1283 LAKE BARKLEY DRIVE KUTTAWA, KY 42066	
(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 371	Continued From page 11	F 371		
F 600 SS=B	<p>An interview conducted with the Registered Dietitian (RD) on 03/13/13, at 1:45 PM, revealed food delivered to residents eating in the dining room was never covered by the facility. The RD stated she monitored food being covered; however, she only monitored food being covered that was delivered to residents in the resident bedrooms. The RD stated she had not identified serving uncovered meal trays in the dining room as being an infection control concern. The RD stated she was not aware of the facility policy related to covering trays for residents in the dining room.</p> <p>483.76(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT</p> <p>If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section.</p> <p>Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 600	<p><u>F 500</u></p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Residents</u></p> <p>Dialysis contract with outside dialysis center was obtained on 4/4/13 by the Administrator. Residents #2, C, and D continue to receive dialysis from the outside dialysis center.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current residents receiving dialysis have the potential to be affected.</p>	

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

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055		
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F 500	<p>Continued From page 12</p> <p>Based on interview and record review, the facility failed to ensure there was a written agreement with an outside dialysis center. Three of the facility's census of sixty-three residents received dialysis services (Residents #2, C, and D). One of the three residents was selected for review (Resident #2).</p> <p>The findings include:</p> <p>Interview with the Administrator on 03/14/13, at 11:35 AM, revealed she was unable to produce a contract with the dialysis center. The Administrator also stated the facility did not have a policy related to contracts with outside agencies.</p> <p>Interview with the Administrator on 03/14/13, at 11:35 AM revealed Resident #2, Resident C, and Resident D received services from the outside dialysis center.</p> <p>Review of the medical record for Resident #2 revealed the facility admitted Resident #2 on 05/02/12, with a diagnosis of End Stage Renal Disease. Documentation revealed Resident #2 received dialysis from the outside dialysis center on a weekly basis.</p> <p>An interview conducted with the Administrator on 03/14/13, at 11:35 AM, revealed the facility did not provide dialysis services. Although the Administrator was aware the facility was required to obtain a contract, the Administrator stated she had not checked for the contracts when the residents were admitted and required dialysis, and was uncertain if the facility had a contract with an outside dialysis center.</p>	F 500	<p><u>Systematic Changes</u></p> <p>The Administrator was in-serviced by the consultant on 3/14/13 regarding the need for a dialysis contract to be in place. A dialysis contract with the outside dialysis center was obtained on 4/4/13 by the Administrator.</p> <p>When a resident requiring dialysis is being reviewed for possible admission, the Director of Nursing and/or Admission Director will confirm with the Administrator that a contract has been, or will be, executed prior to admitting the resident.</p> <p><u>Monitoring</u></p> <p>The Administrator and Director of Nursing will audit dialysis contracts bi-annually for one year, and then annually. Information from audit will be presented at the monthly Performance Improvement Committee meeting by the Director of Nursing. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.</p>	4/28/13	

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

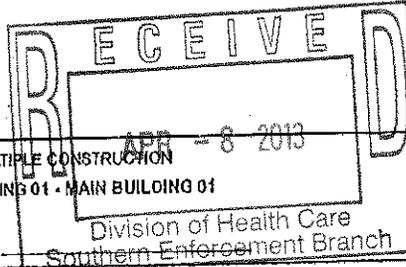
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS 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: 186318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/13/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42056
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1955 and 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Eight (8)</p> <p>FIRE ALARM: Complete fire alarm system installed in 1980 and upgraded in 1997, with 38 smoke detectors and 14 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1984.</p> <p>GENERATOR: Type II generator installed in 1991. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/13/13. Christian Care Center of Kuttawa, LLC was found in noncompliance with the requirements for participation in Medicare and Medicaid. The facility is certified for 65 beds with a census of 63 on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cindy Britton* TITLE: *Administrator* (X6) DATE: *4-8-13*

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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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
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K 000	Continued From page 1	K 000		
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect five of eight smoke compartments, eighteen residents, staff, and visitors. The facility is certified for 85 beds with a census of 83 on the day of the survey. The facility failed to ensure the gap around the doorjamb was less than one-half</p>	K 018	<p>K 018</p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Areas</u></p> <p>Door latches to resident rooms 112, 105 and 106 were repaired by the Director of Maintenance on 3/28/13, and are working properly.</p> <p>Doors to resident rooms 101, 229, 445, 446, 448, 449, 455, 507, 506, 502, 501, 339, 340, 335, and 334 have had caulking placed along the door jambs by the Director of Maintenance on 3/28/13. These door jambs will now maintain a gap no larger than ½ inch.</p> <p><u>Identification of Other Areas with Potential to be Affected</u></p> <p>On 3/28/13, the Director of Maintenance audited facility doors to ensure they latch positively and maintain a gap of no larger than ½ inch. No other areas were found to be affected.</p>	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42065	
(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 018	<p>Continued From page 2</p> <p>inch for fifteen corridor doors leading into the resident rooms. In addition, the facility failed to ensure three doors leading into resident rooms 112, 105, and 106 had a means suitable for keeping the doors latched when closed.</p> <p>The findings include:</p> <p>Observations on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed the corridor doors to rooms 101, 229, 445, 446, 448, 449, 455, 507, 508, 602, 601, 339, 340, 335, and 334 had a gap larger than one-half inch around the jamb.</p> <p>Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed he was unaware of the acceptable gap around the doors.</p> <p>Observations on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed the doors to resident rooms 112, 105, and 106 did not latch when closed.</p> <p>Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed he was unaware these three doors were not latching.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than</p>	K 018	<p><u>Systematic Changes</u></p> <p>The Administrator in-serviced the Maintenance Director on 3/15/13 on the requirement of maintaining doors so that they latch and they do not have a gap of more than 1/4 inch around the jamb when shut.</p> <p><u>Monitoring</u></p> <p>The Director of Maintenance will audit resident doors weekly for one month, then monthly to ensure a means suitable for keeping the doors latched when closed, and to ensure there is no gap larger than 1/4 inch around the door jambs. This will be done monthly for three months, then quarterly. The Director of Maintenance will present results of the audits to the Performance Improvement Committee to ensure that continued compliance. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.</p>	4/28/13

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42085	
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K 018	<p>Continued From page 3</p> <p>20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.</p> <p>S&C Letter 07-18 In a smoke compartment that is not fully sprinklered, a gap not exceeding 1/4-inch between the face of a corridor door and the doorstop should be permitted, provided that the door latch mechanism is functioning. In a smoke compartment that is fully sprinklered, a gap not exceeding 1/2-inch between the face of a corridor door and the doorstop should be permitted,</p>	K 018		

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K 018	Continued From page 4	K 018		
K 029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect four of eight smoke compartments, twenty-four residents, staff, and visitors. The facility is certified for 65 beds with a census of 63 on the day of the survey. The facility failed to ensure eight rooms were properly protected due to the storage of combustibles in the rooms.</p> <p>The findings include:</p> <p>Observation on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed:</p>	K 029	<p><u>K 029</u></p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Areas</u></p> <p>The Director of Maintenance installed door closers on the maintenance office door, room 115, room 113, dry storage room in the kitchen, laundry room in the kitchen, housekeeping office, soiled utility room on Wing 2, and med room on Wing 3. This was completed by 3/28/13.</p> <p><u>Identification of Other Areas with Potential to be Affected</u></p> <p>The Director of Maintenance has audited rooms/offices for the need to install door closers. Closers were also installed on the doors of the three medical storage areas and the generator room. This was completed by 4/4/13.</p>	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42065	
(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 029	<p>Continued From page 5</p> <ul style="list-style-type: none"> -The maintenance office did not have a door closer installed due to the storage of combustibles in the room. -Room 116 did not have a door closer installed due to the storage of combustibles in the room. -Room 113 did not have a door closer installed due to the storage of combustibles in the room. -The dry storage room in the kitchen did not have a door closer installed due to the storage of combustibles in the room. -The laundry room door with the closer did not latch. -The housekeeping office did not have a door closer installed due to the storage of combustibles in the room. -The soiled utility on Wing 2 did not have a door installed and was over 50 square feet with combustibles stored. -The Wing 3 med room did have a door closer installed but it was taken apart. <p>Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in</p>	K 029	<p><u>Systematic Changes</u></p> <p>On 3/15/13, the Maintenance Director was in-serviced by the Administrator on the requirement that doors must have self-closers to protect from hazardous areas.</p> <p><u>Monitoring</u></p> <p>The Director of Maintenance will audit rooms/offices monthly for three months, then quarterly, to ensure that proper closers are on the doors thereby ensuring the proper storage of combustibles. The Director of Maintenance will bring results of the audits to the Performance Improvement Committee monthly for three months, then quarterly. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.</p>	4/28/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 029	Continued From page 6 accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	<u>K 038</u> Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect eight of eight smoke compartments, all residents, staff, and visitors. The facility is certified for 65 beds with a census of 63 on the day of the survey. The facility failed to ensure four egress doors had the proper signage for delayed egress doors.</p> <p>The findings include:</p> <p>Observation on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed the egress doors at the back of Wing 1, back Wing 2, lakeside exit, and the front doors were equipped with delayed egress signs that had a clear background which was not contrasting to the lettering.</p> <p>Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed he was unaware the doors were required to have signage with a contrasting background.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in</p>	K 038	<p><u>Corrective Actions for Targeted Areas</u></p> <p>The Director of Maintenance has ensured that the egress doors have the proper signage for delayed egress doors by placing signs with white background and contrasting lettering on the doors of Wing 1, Wing 2, and front doors. All areas were completed by 3/28/13.</p> <p><u>Identification of Other Areas with Potential to be Affected</u></p> <p>The Director of Maintenance completed auditing other egress doors by 3/28/13. No other areas were affected.</p> <p><u>Systematic Changes</u></p> <p>The Administrator in-serviced the Maintenance Director on 3/15/13 regarding the requirement for contrasting background and lettering on delayed egress doors.</p> <p><u>Monitoring</u></p> <p>The Director of Maintenance will audit doors monthly for three months, then quarterly, to ensure that signs with contrasting background and lettering are in place on delayed egress doors. The Director of Maintenance will report the audit results to the Performance Improvement Committee monthly. This Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity</p>	

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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: 186318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1283 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 8 health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.6.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process	K 038	Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.	4/28/13

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

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42065	
(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 038	Continued From page 9 shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 045 SS=E	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards to ensure that in the failure of any single lighting unit, the illumination level would not be less than 0.2 ft-candle in any designated area. The deficiency had the potential to affect three of eight smoke compartments, twenty-eight residents, staff, and visitors. The facility is certified for 85 beds with a census of 83 on the day of the survey. The facility failed to ensure the	K 045	<u>K 045</u> Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Areas</u> Exits at the back of Wing 1 and Wing 2 currently have more than one light for illumination and were in place prior to the survey date. This was confirmed by the Director of Maintenance on 3/13/13.	

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

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 10 emergency lights had two bulbs at two exits. The findings include: Observation on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed the exterior exits at the back of Wing 1 and Wing 2 only had a single light for illumination of the outside of the exit. Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Reference: NFPA 101 (2000 Edition). 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. NFPA 101 LIFE SAFETY CODE STANDARD	K 045	<u>Identification of Other Areas with Potential to be Affected</u> Other exits currently have more than one light for illumination and were in place prior to survey date. This was confirmed by the Director of Maintenance on 3/13/13. <u>Systematic Changes</u> The Administrator in-serviced the Director of Maintenance on 3/15/13 regarding the requirement of illuminating means of egress, and that fixtures are arranged so that failure of any single light bulb will not leave the area in darkness. <u>Monitoring</u> The Director of Maintenance will monitor monthly for proper illumination and will report findings of audits to the Performance Improvement Committee, which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.	
K 056 SS=D	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		4/28/13

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42066	
(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 045	Continued From page 10 emergency lights had two bulbs at two exits. The findings include: Observation on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed the exterior exits at the back of Wing 1 and Wing 2 only had a single light for illumination of the outside of the exit. Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Reference: NFPA 101 (2000 Edition). 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	<u>K 056</u> Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Areas</u> The Director of Maintenance removed the ceiling fan from the MDS office on 3/28/13 to ensure the sprinkler head is not blocked. The contracted sprinkler service vendor	

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 11 This STANDARD is not met as evidenced by: Based on observations and Interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect two of eight smoke compartments, residents, staff, and visitors. The facility is certified for 65 beds with a census of 63 on the day of the survey. The facility failed to ensure the five sprinkler heads were not blocked by light fixtures. The findings include: Observations on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed the sprinkler heads located in the kitchen and the MDS Coordinator office were blocked by light fixtures, within one foot of the sprinkler head, extending below the sprinkler heads. Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head. Reference: NFPA 13 (1999 Edition). 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords.	K 066	lowered four sprinkler heads in the kitchen on 4/4/13 to ensure the sprinkler heads were not blocked. <u>Identification of Other Areas with Potential to be Affected</u> By 3/28/13, the Director of Maintenance had completed auditing sprinkler heads to ensure they are free and clear of blockage. <u>Systematic Changes</u> The Administrator in-serviced the Director of Maintenance on 3/15/13 regarding the proper placement of sprinkler heads to prevent blockage. The Director of Maintenance will consult with the contracted sprinkler company during their quarterly inspection on proper placement of sprinkler heads to prevent any heads from being blocked. <u>Monitoring</u> The Director of Maintenance will audit the sprinkler heads monthly for three months, then quarterly, to ensure compliance. The Director of Maintenance will report the audit findings to the Performance Improvement Committee for review. This Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.	4/28/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 12 pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP) Maximum Allowable Distance Distance from Sprinklers to of Deflector above Bottom of Side of Obstruction (A) Obstruction (in.) (B) Less than 1 ft 0 1 ft to less than 1 ft 6 in. 21/2 1 ft 6 in. to less than 2 ft 31/2 2 ft to less than 2 ft 6 in. 51/2 2 ft 6 in. to less than 3 ft 71/2 3 ft to less than 3 ft 6 in. 91/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 161/2 5 ft and greater 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 Edition). 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	<u>K 062</u> Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42065	
(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 062	Continued From page 13 Based on record review and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect eight of eight smoke compartments, all residents, staff, and visitors. The facility is certified for 65 beds with a census of 63 on the day of the survey. The facility failed to ensure the dry sprinkler system had a full flow trip test since 04/23/09. The findings include: Record review on 03/13/13 at 12:23 PM with the Director of Maintenance revealed the facility failed to provide documentation that the dry sprinkler system had a full flow trip test performed in the last three years. Documentation revealed the last full flow trip test was performed on 04/23/09. Interview on 03/13/13 at 12:23 PM with the Director of Maintenance revealed he was unaware the trip test was past due since he was new to the facility and his paperwork showed the test was to be performed every five years. Reference: NFPA 26 (1998 Edition). 9-4.4.2.2.1* Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service. 9-4.4.2.2.2* During those years when full flow testing in accordance with 9-4.4.2.2.1 is not required, each dry pipe valve shall be trip tested with the control valve partially open.	K 062	<u>Corrective Actions for Targeted Areas</u> The contracted sprinkler service provider completed a Full Flow Trip Test on 4/5/13. Sprinkler system is fully functional and operating properly. <u>Identification of Other Areas with Potential to be Affected</u> The Director of Maintenance reviewed the inspection calendar with the contracted sprinkler company on 4/4/13, and found no other areas were affected. <u>Systematic Changes</u> The Director of Maintenance was in-serviced by the Administrator on 3/15/13 regarding the inspection calendar for the sprinkler system. The Maintenance Director will consult with the contracted sprinkler company during their quarterly inspections on proper sprinkler testing. <u>Monitoring</u> The Director of Maintenance will audit the sprinkler inspection calendar quarterly and will report results of audits to the Performance Improvement Committee on an annual basis. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.	
K 072	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		4/28/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186310	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 072 SS=E	<p>Continued From page 14</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three of eight smoke compartments, twenty-eight residents, staff, and visitors. The facility is certified for 65 beds with a census of 63 on the day of the survey. The facility failed to ensure carts were properly stored out of the corridor when not in use and that an exit corridor was kept free of a chain across the corridor.</p> <p>The findings include:</p> <p>Observation on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed several carts were stored in the corridor at the back exit by the kitchen. Further observation revealed a chain across the corridor blocking the exit.</p> <p>Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed the facility routinely stored the carts in the corridor and the chain was placed across this corridor to keep residents from wandering down</p>	K 072	<p><u>K 072</u></p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Areas</u></p> <p>The dietary carts were moved by the Dietary Manager on 3/26/13, and will ensure means of egress are maintained free of obstructions by properly storing carts out of the corridor. In addition, on 3/26/13, the Director of Maintenance removed the chain that was across the service hall entrance to un-block the exit.</p> <p><u>Identification of Other Areas with Potential to be Affected</u></p> <p>The Director of Maintenance did a walk-through of the facility on 3/14/13 and found all other areas of egress to be free of obstruction.</p> <p><u>Systematic Changes</u></p> <p>The Director of Maintenance, Dietary Manager, and House Supervisor will perform daily audits of the egress doors throughout the facility. The Administrator, Housekeeping Supervisor, Dietary Manager and the Department Managers will look daily for items stored in areas of egress and</p>	
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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: 186318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
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K 072	Continued From page 15 the corridor. Reference: NFPA 101 (2000 Edition). Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	resolve immediately. Staff was in-serviced by the Maintenance Director and Administrator on 4/5/13 regarding the importance of maintaining the means of egress free of obstructions and proper storage of carts. <u>Monitoring</u> The daily audits will be submitted to the Administrator monthly for three months to ensure compliance. The Administrator will report the audit results to the Performance Improvement Committee monthly. This Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.	4/28/13
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four of eight smoke compartments, forty-five residents, staff, and visitors. The facility is certified for 85 beds with a census of 83 on the day of the survey. The facility to ensure six power strips were being used properly and that a sufficient number of receptacles were located to avoid the need for extension cords or multiple-outlet adapters. The findings include: Observations on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed:	K 147 <u>K 147</u> Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:		

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

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K 147	<p>Continued From page 18</p> <ul style="list-style-type: none"> -An air conditioning unit was plugged into a power strip located in the employee break room. -A vending machine was plugged into a power strip located in the employee break room. -A mini nebulizer was plugged into a power strip located in room 108. -A bed air mattress was plugged into a power strip located in room 103. -A power strip was plugged into a multi-plug adapter located in the therapy office. -A hydrocollator was plugged into a standard plug located in the therapy office. -A bed was plugged into a power strip located in room 501. -An air conditioning unit was plugged into a multi-plug adapter located in the Assistant Director of Nursing Office. <p>Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed he was aware of the proper use of power strips but was new to the facility and was working on adding more electrical outlets.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p><u>Corrective Actions for Targeted Residents</u></p> <p>A certified electrician ran a new outlet to the employee break room for the air conditioning unit, and the power strip was removed from the vending machine plug. The Maintenance Director removed the power strips in rooms 108, 103, 501, and therapy office. The certified electrician installed a GFI outlet in the therapy office. The Director of Maintenance removed the multi-plug in the Assistant Director of Nursing's office. These actions were all completed by 3/28/13.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>The Director of Maintenance audited rooms/offices on 3/28/13 and no other areas were affected.</p> <p><u>Systematic Changes</u></p> <p>Staff was in-serviced by the Maintenance Director and the Administrator on 4/5/13 regarding sufficient receptacles being located in order to avoid the need for multiple outlet adapters in patient care areas.</p> <p><u>Monitoring</u></p> <p>Daily rounds will be completed for one month, then weekly for three months, then quarterly, by the Maintenance Director and Housekeeping Supervisor to inspect for</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
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K 147	<p>Continued From page 16</p> <ul style="list-style-type: none"> -An air conditioning unit was plugged into a power strip located in the employee break room. -A vending machine was plugged into a power strip located in the employee break room. -A mini nebulizer was plugged into a power strip located in room 108. -A bed air mattress was plugged into a power strip located in room 103. -A power strip was plugged into a multi-plug adapter located in the therapy office. -A hydrocollator was plugged into a standard plug located in the therapy office. -A bed was plugged into a power strip located in room 501. -An air conditioning unit was plugged into a multi-plug adapter located in the Assistant Director of Nursing Office. <p>Interview on 03/13/13 between 12:30 PM and 2:00 PM with the Director of Maintenance revealed he was aware of the proper use of power strips but was new to the facility and was working on adding more electrical outlets.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>non-compliance of electrical wiring safety regulations. Housekeeping staff will be instructed to be aware of these items and to report to the Administrator, Housekeeping Supervisor, Maintenance Director or House Supervisor of any electrical items that need to be removed. The results of these inspections will be reported to the Performance Improvement Committee, which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Housekeeping Director, Medical Director, Consultant Pharmacist, Human Resource Manager, and Business Office Manager.</p>	4/28/13