

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

PRINTED: 10/08/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/24/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE CORBIN, KY 40702	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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)
F 000	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted on 09/22-24/15. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p><b>F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</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 services in accordance with the written plan of care for one (1) of eighteen (18) sampled residents (Resident #11). Review of Resident #11's Comprehensive Care Plan revealed fall interventions for Resident #11 were to have a low bed and to have a pressure pad alarm to his/her bed. However, observation on 09/23/15 revealed Resident #11's bed was not in the lowest position and the bed sensor alarm was not present to his/her bed.</p> <p>The findings include:</p> <p>Review of the facility policy, "Implementation of Plan of Care," dated May 2014, revealed all staff was to follow the Plan of Care as written for each resident to ensure consistency and correct approach for each resident's care.</p> <p>Review of Resident #11's medical record revealed the facility admitted Resident #11 on</p>	F 000	<p>Preparation or execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required by the provision of federal and state law.</p> <p><b>F 282</b></p> <ol style="list-style-type: none"> <li>1. Resident # 11- A Falls Risk assessment was completed on 09/23/15 by a licensed nurse. Alarm use and low bed were discontinued. The care plan and resident needs template have been updated to reflect current needs and interventions.</li> <li>2. Nursing Managers reviewed and adjusted the care plans of current residents with intervention for alarm use and/or low bed use to ensure that resident care plans include appropriate fall interventions on 9/25/15. These adjustments will reflect each residents individualized interventions for fall prevention.</li> <li>3. The Care Plan Policy and Following A Care Plan Policy was reviewed by the Administrator and the Director of Nursing on 9/24/15. The Staff Development Coordinator reeducated employees on the Care Plan Policy and Implementation of plan of care on 10/14/15. Resident identified as having changes to their care based upon new orders or approaches will have their care plans reviewed by the licensed nurse, and adjustments will be made to the resident care template to reflect resident individual interventions. The Unit Managers will audit these changes 3 times weekly for 3 months to ensure the nurse and nursing assistants are following the plan of care for implementation of care, and then as directed by the Quality Assurance Performance Improvement Committee.</li> <li>4. The MDS Coordinators will audit each residents care plan in accordance with their quarterly MDS schedule for inclusion of appropriate interventions. These audits will be reviewed with the Director of</li> </ol>

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

*Bill Collins*

TITLE

Administrator

(X6) DATE

10/16/15

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 282	<p>Continued From page 1</p> <p>06/04/09 with diagnoses including Dementia, Anxiety, Depression, Osteoporosis, Anemia, Muscle Weakness, Osteoarthritis, Difficulty in Walking, Generalized Pain, and Peripheral Vascular Disease. Review of Resident #11's Significant Change Quarterly Minimum Data Set (MDS) assessment dated 06/09/15 revealed the facility assessed Resident #11 to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #11 was moderately impaired cognitively. Further review of Resident #11's MDS assessment revealed Resident #11 had sustained a fall with a fracture within the last month. Continued review of Resident #11's medical record revealed Resident #11 had fallen on 05/27/15 and as a result sustained a tibia (shinbone) and fibula (calf bone) fracture. Review of Resident #11's Comprehensive Care Plan, undated, revealed Resident #11 to be at risk for falls with interventions of a low bed and a bed sensor alarm.</p> <p>Observation on 09/23/15 at 3:30 PM revealed Resident #11 to be in bed with the bed not in the lowest position. Continued observation of Resident #11 revealed no bed sensor alarm present on his/her bed.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 09/23/15 at 4:13 PM revealed that he was assigned to the hall where Resident #11 resided. SRNA #1 stated if a resident had an intervention on his/her care plan to have a low bed, then the bed should have been in the lowest position. Continued interview with SRNA #1 revealed he looked at a resident's nurse aide care plan in the computer to find out what care was to be provided for each resident. Further interview with SRNA #1 revealed he did not know</p>	F 282	Nursing who will provide education on an as needed basis. The DON will present these findings to the QAPI committee monthly to ensure accuracy and completeness of the process.	10/16/15

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F 282	<p>Continued From page 2</p> <p>why Resident #11's bed was not in the lowest position and also did not know why Resident #11 did not have a bed sensor alarm present on his/her bed.</p> <p>Interview with SRNA #2 on 09/23/15 at 4:28 PM revealed making sure care plan interventions were followed was both a nurse aide and nurse responsibility. Continued interview with SRNA #2 revealed if a resident had an intervention for a low bed the bed should be in the lowest position.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, the nurse assigned to care for Resident #11, on 09/23/15 at 4:28 PM revealed that an intervention for a low bed meant that a resident's bed should have been in the lowest position. Continued interview with LPN #1 revealed she did rounds daily to ensure care plans were being followed. Further interview with LPN #1 revealed she was not aware of Resident #11's bed not being in the lowest position and was also not aware that Resident #11 did not have a bed sensor alarm present to his/her bed. LPN #1 stated she expected nurse aides to look at each resident's nurse aide care plan to ensure proper care had been provided.</p> <p>Interview with the Second Floor Unit Manager (UM) on 09/23/15 at 4:33 PM revealed nurse aides should have checked for alarms to ensure that they were present on Resident #11's bed. Continued interview with the UM revealed the low bed intervention listed on Resident #11's care plan was not a fall intervention and that all nonambulatory residents in the facility have their beds placed in the lowest position at night. Further interview with the UM revealed she was not sure why Resident #11 did not have a bed</p>	F 282			

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F 282	<p>Continued From page 3</p> <p>sensor alarm in place. Interview with the Second Floor UM on 09/24/15 at 1:49 PM revealed she conducted spot checks on approximately ten resident rooms weekly to ensure care plans had been followed and had not identified any concerns. Further interview with the UM revealed the facility quality assurance committee conducted monthly audits to ensure care plans were being followed. Continued interview with the UM revealed nurses and nurse aides should look at each resident's care plan daily.</p> <p>Interview with the facility Director of Nursing (DON) on 09/24/15 at 2:23 PM revealed she conducted rounds with the facility administrator daily to ensure residents' care plans were being followed and that the quality assurance committee met monthly to ensure care plans were being followed. Continued interview with the DON revealed a morning meeting was conducted daily to discuss any concerns, updates, and/or revisions that may need to be made to a resident's care plan. Continued interview with the DON revealed that low bed means a resident's bed should be in the lowest position possible. Further interview with the DON revealed Resident #11's low bed had not been intended to be an intervention related to falls. Further interview with the DON revealed the bed sensor alarm was not intended to be a long-term intervention for Resident #11 and that it was just an intervention put in place when Resident #11 returned to the facility from the hospital.</p>	F 282	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards</p>	F 323	<p>1. Resident # 11- A Falls Risk assessment was completed 09/23/15 by a licensed nurse. Alarm use and low bed were discontinued. The care plan and resident needs template have been updated to reflect current needs and interventions.</p>

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F 323	<p>Continued From page 4</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</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 ensure residents were as free of accident hazards as possible and that assistive devices were provided to prevent accidents for one (1) of eighteen (18) sampled residents (Resident #11). Review of Resident #11's Comprehensive Care Plan revealed fall interventions for Resident #11 were to have a low bed and to have a pressure pad alarm to his/her bed. However, observation on 09/23/15 revealed the fall interventions for Resident #11 were not implemented.</p> <p>The findings include:</p> <p>Review of the facility policy, "Falls Prevention," undated, revealed through assessment and intervention the facility would provide supervision and assistance to residents in an effort to avoid falls and minimize injury that may result from a resident falling.</p> <p>Review of Resident #11's medical record revealed the facility admitted Resident #11 on 06/04/09 with diagnoses including Dementia, Anxiety, Depression, Osteoporosis, Anemia, Muscle Weakness, Osteoarthritis, Difficulty in Walking, Generalized Pain, and Peripheral Vascular Disease. Review of Resident #11's</p>	F 323	<p>2. Any resident with a fall in the past 30 days will be reviewed by a licensed nurse to assure the root cause was identified and the intervention utilized was appropriate by 10/16/15. The care plans and C.N.A. care plans will be reviewed and revised if needed by a licensed nurse to ensure accuracy. All residents will have their falls risk assessment completed with their MDS schedule. Residents identified as being at risk for fall will have a Falls Risk care plan initiated based on individual risk factors.</p> <p>3. The Falls Prevention and The Root Cause Analysis policy was reviewed by the Administrator and the Director of Nursing on 9/23/15. The Staff Development Coordinator reeducated employees on Falls Prevention and Root Cause Analysis on 10/14/15. The Interdisciplinary Team will audit the root cause analysis and any interventions implemented 5 times weekly for 3 months, and then as determined by the Quality assurance Performance Improvement Committee. These audits will be reviewed by the Director of Nursing monthly who will provide education on an as needed basis.</p> <p>4. The Director of Nursing will present these finding to the Quality Assurance Performance Improvement Committee monthly to ensure accuracy and completeness of the process.</p>	10/16/15	

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F 323	<p>Continued From page 5</p> <p>Significant Change Quarterly Minimum Data Set (MDS) assessment dated 06/09/15 revealed the facility assessed Resident #11 to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #11 was moderately impaired cognitively. Further review of Resident #11's MDS assessment revealed Resident #11 had sustained a fall with a fracture within the last month. Continued review of Resident #11's medical record revealed Resident #11 had fallen on 05/27/15 and as a result sustained a tibia (shinbone) and fibula (calf bone) fracture. Review of Resident #11's Comprehensive Care Plan, undated, revealed Resident #11 to be at risk for falls with interventions for a low bed and a bed sensor alarm.</p> <p>Observation on 09/23/15 at 3:30 PM revealed Resident #11 to be in bed with the bed not in the lowest position. Continued observation of Resident #11 revealed no bed sensor alarm was present on his/her bed.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 09/23/15 at 4:13 PM revealed he was assigned to the hall where Resident #11 resided. SRNA #1 stated that if a resident had an intervention on his/her care plan to have a low bed, then the bed should have been in the lowest position. Further interview with SRNA #1 revealed he looked at a resident's nurse aide care plan in the computer to find out what care was to be provided for each resident. Continued interview with SRNA #1 revealed he did not know why Resident #11's bed was not in the lowest position and also did not know why Resident #11 did not have a bed sensor alarm present on his/her bed.</p>	F 323	

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F 323	<p>Continued From page 6</p> <p>Interview with SRNA #2 on 09/23/15 at 4:28 PM revealed making sure care plan interventions were followed was both a nurse aide and nurse responsibility. Further interview with SRNA #2 revealed if a resident had an intervention for a low bed then the bed should be in the lowest position.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 09/23/15 at 4:28 PM revealed that an intervention for a low bed meant that a resident's bed should have been in the lowest position. Further interview with LPN #1 revealed she did rounds daily to ensure care plans were being followed. Continued interview with LPN #1 revealed she was not aware of Resident #11's bed not being in the lowest position and was not aware that Resident #11 did not have a bed sensor alarm present to his/her bed. LPN #1 stated she expected nurse aides to look at each resident's nurse aide care plan to ensure proper care had been provided.</p> <p>Interview with the Second Floor Unit Manager (UM) on 09/23/15 at 4:33 PM revealed nurse aides should have checked for alarms to ensure that they were present on Resident #11's bed. Further interview with the UM revealed the low bed intervention listed on Resident #11's care plan was not a fall intervention and that all nonambulatory residents in the facility have their beds placed in the lowest position at night. Continued interview with the UM revealed she was not sure why Resident #11 did not have a bed sensor alarm in place. Interview with the Second Floor UM on 09/27/15 at 1:49 PM revealed she conducted spot checks on approximately ten resident rooms weekly to ensure fall interventions were in place and had not identified any concerns. Continued interview</p>	F 323			

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F 323	Continued From page 7 with the UM revealed the facility quality assurance committee conducted monthly audits to ensure fall interventions were in place. Further interview with the UM revealed nurses and nurse aides should look at each resident's care plan daily.  Interview with the facility Director of Nursing (DON) on 09/24/15 at 2:23 PM revealed she conducted rounds with the facility administrator daily to ensure residents' care plans were being followed and that the quality assurance committee met monthly to ensure fall interventions were in place. Continued interview with the DON revealed a morning meeting was conducted daily to discuss any concerns, updates, and/or revisions that may need to be made to a resident's care plan/interventions. Further interview with the DON revealed that low bed means a resident's bed should be in the lowest position possible. Continued interview with the DON revealed Resident #11's low bed had not been intended to be an intervention related to falls. Further interview with the DON revealed the bed sensor alarm was not intended to be a long-term intervention for Resident #11 and that it was just an intervention put in place when Resident #11 returned to the facility from the hospital.	F 323			

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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: 1989</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: 3-story, Type 11 (222)</p> <p>SMOKE COMPARTMENTS: 7</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 09/24/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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