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

PRINTED: 09/26/2011
FORM APPROVED
OMB NO. 0938-0391

RECEIVED SEP 2011 OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	186419		08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CENTER	1000 WESTERN AVENUE BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey was conducted on 08/09/11 through 08/11/11 and a Life Safety Code survey was conducted on 08/10/11 to determine the facility's compliance with Federal regulatory requirements. Deficiencies were cited in regard to the Life Safety Code survey with the highest scope and severity being an "F" and the facility having an opportunity to correct before remedies could be recommended for imposition.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melanie Eaton
TITLE: Administrator
(X6) DATE: 09/01/2011

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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	186419	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/10/2011

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CHRISTIAN HEALTH CENTER	1800 WESTEN AVENUE BOWLING GREEN, KY 42104

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1995 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V Unprotected SMOKE COMPARTMENTS: Two (2) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system. GENERATOR: Type II generator installed in 1995. Fuel source is diesel. A standard Life Safety Code survey was initiated on 08/10/11, and concluded on 08/10/11. Christian Health Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for twenty eight (28) beds with a census of twenty seven (27) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melanie Eaton
TITLE: Administrator
(X6) DATE: 9/12/2011

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

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K 000	Continued From page 1	K 000		
	Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a)			
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, visitors, and staff. The facility is	K 018	1. The facility removed door stops from shower rooms 1 and 2 located in 300 Hall. 2. All residents utilize shower room 1 and 2, located in the 300 Hall, and have the potential to be affected by the deficient practice. 3. To ensure the deficient practice will not recur, doorstops on shower doors 1 and 2, in 300 Hall, have been removed. The maintenance staff was in-serviced, by the Housing Manager, on August 29, 2011 to not install door stops on shower door 1 and 2, in 300 Hall. 4. To monitor its performance to ensure that solutions are sustained, the facility Housing Manager will conduct monthly inspections for three months on shower room 1 and 2, on 300 Hall, to ensure that that no door stops have been added. Inspection will be presented to the Administrator monthly for three months and the Administrator will present to QA for recommendations on changes and duration of inspections.	08/29/11

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K 018	Continued From page 2 licensed for twenty eight (28) beds with a census of twenty seven (27) on the day of the survey. The findings include: Observation, on 08/10/11 at 10:46 AM, with the Housing Manager revealed the corridor doors on shower room 1, and 2, located in the 300 Hall, were equipped with unapproved hold open devices. Interview, on 08/10/11 at 10:45 AM, with the Housing Manager revealed the facility was unaware the hold open devices on the shower room doors were unapproved. Reference: NFPA 101 (2000 edition) 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 20 minutes and shallbe constructed to resist the passage of smoke. Compliancewith 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	K 018		

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K 018	Continued From page 3 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. 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 19.3.5.2. 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: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or	K 018		

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K 018	Continued From page 4 plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is licensed for twenty eight (28) beds with a census of twenty seven (27) on the day of the survey. The findings include: Observation, on 08/10/11 at 11:20 AM, with the Housing Manager revealed the smoke partition	K 025	1. The smoke partition extended above the ceiling, located in the attic, was sealed with a smoke barrier with one half hour fire resistance rating in accordance with 8.3. 2. Due to deficient practice located in 2 of 2 smoke compartments, all residents have the potential to be affected. 3. To ensure the deficient practice will not recur, the maintenance staff will be in-serviced monthly for three months that the smoke barriers are not to be penetrated and a smoke barrier inspection is required following the completion of any contractors work. 4. To monitor its performance and ensure that solutions are sustained, the housing manager will conduct monthly inspections, to ensure no smoke barriers have been penetrated once per month for three months of smoke compartments per NFPA standards. The housing manager will present the in-services and inspections to the Administrator, monthly for three months, and the Administrator will present to QA for recommendations on changes and duration of inspections.	08/29/11

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K 025	Continued From page 5 extending above the ceiling, located in the attic, was noted to be penetrated. The smoke partition could not resist the passage of smoke. Interview, on 08/10/11 at 11:20 AM, with the Housing Manager revealed he was unaware of the penetration. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		

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K 025	Continued From page 6 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.	K 025		
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: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is licensed for twenty eight (28) beds with a census of twenty seven (27) on the day of the survey. The findings include: Observation, on 08/10/11 at 11:25 AM with the Housing Manager revealed insulation had fallen on the sprinkler heads located in the attic above the 200 Hall.	K 062	1. Fireguard, the facility sprinkler service contractor, was contacted by housing manager. An interior pipe inspection is scheduled and will be completed by September 20, 2011 and the sprinkler pipe located above 200 Hall will be lowered. Sprinkler system is fully functional until inspection can be completed. 2. Due to the insulation on the sprinkler heads in the attic above 200 Hall, and no interior pipe inspection of the automatic sprinkler system, which is utilized throughout the facility, all residents had the potential to be affected by the deficient practice. 3. To ensure the deficient practice will not recur, on 08/29/2011 the maintenance staff were in-serviced by the Housing Manager on inspection of sprinkler heads in the attic above 200 Hall and also on the requirement of an interior pipe inspection of the automatic sprinkler system to be completed every five years by a qualified service contractor. The sprinkler head inspection will be completed at minimum two times a year by	08/31/11

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K 062	Continued From page 7 Interview, on 08/10/11 at 11:25 AM, with the Housing Manager revealed he was unaware of the fallen insulation laying on the sprinkler heads. Sprinkler testing record review, on 08/10/11 at 11:30 PM, with the Housing Manager revealed the facility had never had an interior pipe inspection. The sprinkler system is sixteen (16) years old. Interview, on 08/10/11 at 11:30 AM, with the Administrator and the Housing Manager at the Exit Conference revealed they were unaware the inspection of the automatic sprinkler system was incomplete. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not	K 062	maintenance staff to ensure sprinkler heads are free from obstruction to the sprinkler discharge pattern. 4. To monitor its performance and ensure that solutions are sustained the facility Housing Manager will conduct inspections of the sprinkler heads in the attic above 200 Hall, once per month for three months and will present the inspection to the Administrator monthly for three months. The Administrator will present to QA for recommendations and changes and duration of inspections. To monitor the interior pipe inspections for the facility, the required inspection will be added to the facility preventative maintenance manual to be completed every five years. Completion of interior pipe inspection will be presented to Administrator and the Administrator will present to QA for further recommendation and review.	

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K 062	Continued From page 8 been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.	K 062		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access according to NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility is licensed for twenty eight (28) beds with a census of twenty seven (27) the day of the survey. The findings include:	K 072	1. Linen carts and lifts will not be stored in Hall 100, 200 and 300. 2. All residents reside in either Hall 100, 200 or 300; therefore, all residents have the potential to be affected by deficient practice. 3. To ensure the deficient practice will not recur, linen carts will be brought up by environmental services staff on bed change days for use by C.N.A staff. While in use, linen carts are kept on one side of the hall. One linen cart will be kept in sitting room unless in use by staff to change bed linens. Lifts are taken to the hall in which they are being utilized. All lifts are frequently used in resident care. During meals, at night while residents are sleeping and when lifts are not being utilized, lifts will be stored in an area not used as means of egress, such as shower room 1 and 2, or the sitting area. Environmental	09/09/11

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K 072	Continued From page 9 Observation, on 08/10/11 at 10:40 AM, with the Housing Manager revealed linen carts, and lifts, were being stored in Hall 100, 200, and 300 for periods longer than thirty (30) minutes. Interview, on 08/10/11 at 10:40 AM, with the Housing Manager revealed the facility was lacking in storage space. 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	Services, maintenance and nursing staff were in-serviced at August 11th and 12th employee meetings, by Administrator in Training, on proper storage placement of lifts and linen carts. Orientation of new nursing personnel, maintenance staff and environmental services staff will include means of egress are to be continuously maintained free of obstructions, to include linen carts and lifts. See attached for completion of K 072.	
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 according to NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff, and visitors. The facility is licensed for twenty eight (28) beds with a census of twenty seven (27) on the day of the survey. The findings include: Observation, on 08/10/11 between 9:30 AM and	K 147	1. Maintenance staff removed the two power strips that were together in room 104 on August 10, 2011. Maintenance also removed the curling irons and hair dryers from the power strip in the beauty shop. The refrigerators were removed from the power strip by the Housing Manager immediately during the inspection, on August 10, 2011, in the Med Room. 2. Due to deficient practice, the standard for electrical wiring and equipment by the NFPA National Electric Code was not met and all residents had the potential to be affected. All resident rooms were inspected by Housing Manager and improperly used power strips were removed August 31, 2011. 3. To ensure the deficient practice will not recur, the salon staff was in-serviced by a maintenance worker on August 11 and	08/29/11

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K 072 Plan of Correction, Continued.

4. To monitor its performance, the facility Housing Manager will conduct inspection, of Hall 100, 200 and 300 to ensure means of egress are continuously maintained free of all obstructions, to include linen carts and lifts not in use, monthly for three months. Inspection results will be presented to Administrator for three months, and Administrator will present to QA for recommendations in changes of frequency of inspections.

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

PRINTED: 08/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185419	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CENTER	1800 WESTEN AVENUE BOWLING GREEN, KY 42104

(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 147	Continued From page 10 12:30 PM, with the Housing Manager, revealed: 1) Power strips plugged into each other in room 104. 2) Curling irons and hair dryers plugged into a power strip in the Beauty shop. 3) Two (2) refrigerators plugged into a power strip located in the Med Room behind the Nurses Station. Interview, on 08/10/11 between 9:30 AM and 12:30 PM, with the Housing Manager, revealed he was unaware of the misuse of power strips. Reference: NFPA 99 (1999 edition) 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.	K 147	12, 2011 about improper power strip use per NFPA Code. To ensure that all residents no longer have the potential to be affected, all room inspections are conducted monthly and power strip use will be added to this inspection ongoing, by maintenance staff, and logged in the inspection records. 4. To monitor its performance and ensure that solutions are sustained the facility Housing Manager will conduct inspections of the Health Center rooms, for improper use of power strips, monthly for three months. The inspections will be presented to the Administrator, monthly for three months, and the Administrator will report to QA for recommendations on changes and duration of inspections.	

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