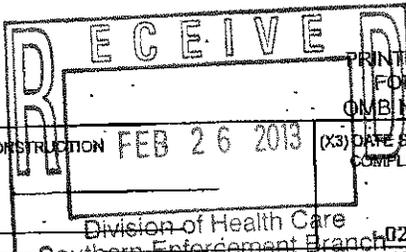


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  02/07/2013
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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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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F 000	INITIAL COMMENTS	F 000	<u>Disclaimer for Plan of Correction</u>	
F 253 SS=E	<p>A standard health survey was conducted on 02/05-07/13. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></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:</p> <p>Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure housekeeping and maintenance services were provided in order to maintain a sanitary, orderly, and comfortable interior. Observations during the environmental tour on 02/07/13 at 1:00 PM revealed shower rooms on the "even" and "odd" hallways had drains that were approximately two-to three inches below the surface of the floor of the shower which created an uneven surface for standing and/or placement of wheels on the shower chairs. In addition, due to the uneven surface of the drain, sharp edges of the tiles surrounding the drain were exposed. Also, a black "mold like" substance was observed on the tile grout in the shower stalls. A shower room on the "MW" hallway had broken tiles around the drain in one of the shower stalls and the drain in the other shower stall had a missing cover.</p> <p>The findings include:</p> <p>A review of the facility's maintenance policy.</p>	F 253	<p>Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Lancaster of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Lancaster 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><b>F 253</b></p> <p>Christian Care Center of Lancaster 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: SUN FRAZIER TITLE: ADMINISTRATOR (X6) DATE: 2/26/13

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</p> <p>(dated August 2008) revealed the Maintenance Department was responsible for maintaining the buildings, grounds, and equipment in a safe operable manner at all times. In addition the Maintenance Department was responsible for maintaining the plumbing fixtures in good working order.</p> <p>A review of the Daily Housekeeper Inspection Report (undated) revealed shower rooms were checked for cleanliness every day.</p> <p>Observation on 02/07/13 at 1:30 PM of the men's and women's shower rooms located on the "even" and "odd" hallways revealed the women's shower had a shower stall floor drain that was approximately two to three inches below the level of the tile which created an uneven floor surface for standing and/or shower chair placement. Due to the uneven surface in the shower stalls, sharp edges of tiles surrounding the drains were exposed. There was a black "mold like" substance on the tile grout in the shower stall around the base of the floor. The drain in the men's shower room was also observed to be two to three inches below the surface of the shower floor which created an uneven surface and exposed sharp edges of tile.</p> <p>Observation of the MW hallway shower rooms conducted on 02/07/13 at 10:00 AM revealed one of the shower rooms had broken tiles in the shower stall around the floor drain in one stall, and the other stall had the cover of the shower floor drain off exposing the open drain and broken tiles.</p> <p>Interview with State Registered Nursing</p>	F 253	<p><u>Corrective Action for Targeted Residents</u></p> <p>The tiles were repaired and drains were replaced in the M/W shower room on 2/7/13 by the Maintenance Department. The tile floors in the men's and women's shower rooms and M/W shower room will be removed by the Maintenance Department and new tile will be placed by 3/18/13 so that the floor surface area and drains will be flush. By removing and replacing the floors in the shower rooms, this will alleviate any broken tiles and the "black mold-like substance."</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Residents that use the shower rooms have the potential to be affected. On 2/8/13 the Director of Maintenance and Administrator completed an audit of shower rooms, thus deciding to remove and retile the shower rooms in question. No additional deficient practices were noted.</p> <p><u>Systematic Changes</u></p> <p>Staff was re-educated prior to and on 2/28/13 by the Administrator and/or the Director of Maintenance on the facility's policy on completing maintenance request orders. The Director of Maintenance will also address this policy when he conducts his portion of orientation for any new hires. The</p>	

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F 253	Continued From page 2 Assistants (SRNAs) #1 and #2 on 02/07/13 at 10:10 AM and 10:25 AM revealed the showers were utilized for resident care. SRNAs #1 and #2 acknowledged the showers had broken tiles, low uneven floor drains, and black "mold like" substance present in the men's and women's showers on the "Odd/Even" hallway and in the M/W halls. Although the SRNAs said they were to report any broken items to the Maintenance Supervisor, the SRNAs acknowledged they had not reported the shower stalls to the Maintenance Supervisor.  Interview with the Housekeeping Supervisor on 02/07/13 at 1:30 PM revealed she and the housekeepers conducted daily rounds of all the showers to monitor for cleanliness/needed repairs. According to the Supervisor, bleach was normally used to clean the "mold like" substance from the showers and stated the housekeepers had tried to clean the black "mold like" substance from the shower stalls but had been unsuccessful.  Interview with the Administrator on 02/07/13 at 1:45 PM revealed he was unaware of the identified concerns related to the men's/women's showers. According to the Administrator, staff was to report problems when they were identified to the appropriate department.	F 253	Housekeeping Department will continue to clean the shower rooms on a daily basis. The Director of Maintenance and the Director of Housekeeping will assure that the shower areas are pressure washed at a minimum semiannually. In addition, the shower areas have been added to all of the weekly Administrative Room Round Audits which are copied to the Director of Maintenance. Any future repairs to the shower areas will be undertaken by the Director of Maintenance as needed.  <u>Monitoring</u> Maintenance issues are discussed every morning, Monday through Friday, during the facility's Stand-Up Meeting, which is presided over by the Administrator. Concerns reported are reviewed and addressed on a daily basis. On weekends, the charge nurses have been instructed to notify the Director of Maintenance of any emergency issues.  A shower area audit is to be completed monthly by the Director of Maintenance. Results of these audits will be presented monthly at the Performance Improvement Committee meetings for a period of 12 months as long as 100% threshold is met. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Consultant Pharmacist, Director of Maintenance,	
F 371 SS=D	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	F 371		

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F 371	Continued From page.3 under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain the confectioner's oven in a sanitary manner. A black substance was observed to cover the bottom of one of two confectioner's ovens.  The findings include:  Review of the facility's policy/procedures for cleaning in the Dietary Department revealed a cleaning schedule would be posted with tasks designated to specific positions in the department. In addition, the policy/procedure revealed the Dietary Manager (DM)/designee or the employee could "check" off assignments or the employee could initial that the task had been completed under the day of the week or weeks.  An initial tour of the Dietary Department was conducted at 10:00 AM on 02/05/13. During the tour, the bottom of the confectioner's oven (the largest oven) was observed to be covered with a black burned-like substance.  The sanitation tour of the Dietary Department at 2:00 PM on 02/07/13 (two days after the initial tour was conducted) revealed the same black burned-like substance continued to cover the bottom of the confectioner's oven (largest oven).	F 371	Dietary Supervisor, Social Services Director, Admissions Coordinator, MDS Coordinator, HR Director, Activities Director and Housekeeping/Laundry Supervisor.  <u>F 371</u>  Christian Care Center of Lancaster 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 Action for Targeted Residents</u>  The convection oven was thoroughly cleaned on 2/7/13 by Dietary personnel, completely removing the "black burned-like substance."  <u>Identification of Other Residents with Potential to be Affected</u>  Current residents have the potential to be affected by this practice. An audit of the dietary cleaning schedule was conducted by the Dietary Manager on 2/7/13. The convection oven cleaning schedule has been changed from a weekly cleaning to a daily cleaning and	3/18/13	

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F 371	<p>Continued From page 4</p> <p>An interview with a dietary staff member at 2:05 PM on 02/07/13 revealed another dietary worker was responsible for the cleaning of the confectioner's oven on Sundays.</p> <p>An interview conducted with the Dietary Manager (DM) at 2:45 PM on 02/07/13 revealed the confectioner's oven was scheduled to have a thorough cleaning every week on Sundays. However, the DM further stated all staff was responsible to clean any spills that occurred during the week. The DM also stated she was aware the confectioner's oven had not been cleaned on Sunday and would not be cleaned until the following Sunday.</p>	F 371	<p>as needed to clean any spills that occur at that time. The only other convection oven was checked for cleanliness on 2/7/13 by Dietary personnel. This oven was found to be clean, resulting in no additional deficient practices.</p> <p><u>Systematic Changes</u></p> <p>On-duty Dietary staff was re-educated by the Dietary Manager on 2/7/13 on convection oven cleaning and the changes to the Dietary cleaning schedule. A Dietary Department staff meeting will be held on 2/28/13 and repeated on 3/12/13 by the Dietary Manager and/or Consultant Registered Dietician for all other Dietary staff regarding the cleaning of convection ovens and changes to the cleaning schedule.</p> <p>Newly-hired Dietary employees will receive education regarding maintaining cleanliness of the convection ovens during their orientation period.</p> <p><u>Monitoring</u></p> <p>An audit regarding maintaining cleanliness of the convection ovens will be conducted daily by the Dietary Manager for two weeks, then weekly for two months, then monthly. This audit will be presented by the Dietary Manager to</p>	

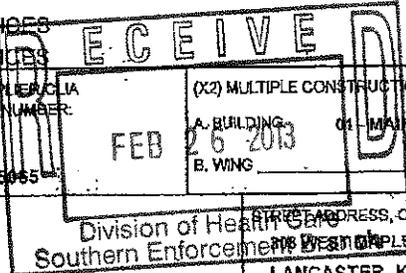
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F 371	Continued From page 4  An interview with a dietary staff member at 2:05 PM on 02/07/13 revealed another dietary worker was responsible for the cleaning of the confectioner's oven on Sundays.  An interview conducted with the Dietary Manager (DM) at 2:45 PM on 02/07/13 revealed the confectioner's oven was scheduled to have a thorough cleaning every week on Sundays. However, the DM further stated all staff was responsible to clean any spills that occurred during the week. The DM also stated she was aware the confectioner's oven had not been cleaned on Sunday and would not be cleaned until the following Sunday.	F 371	the monthly Performance Improvement Committee for review and determination of on-going compliance. This Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Consultant Pharmacist, Director of Maintenance, Dietary Supervisor, Social Services Director, Admissions Coordinator, MDS Coordinator, HR Director, Activities Director and Housekeeping/Laundry Supervisor.	3/18/13

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NAME OF PROVIDER OR SUPPLIER  
**CHRISTIAN CARE CENTER OF LANCASTER**

ADDRESS, CITY, STATE, ZIP CODE  
1850 S. MAIN AVENUE  
LANCASTER, KY 40444

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K 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a)  BUILDING: 01  PLAN APPROVAL: 1985  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type 1 (332)  SMOKE COMPARTMENTS: Six  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLERED, SUPERVISED (WET SYSTEM)  EMERGENCY POWER: Two Type II Diesel generators  A life safety code survey was initiated and concluded on 02/05/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 018	<b>K018</b>  Christian Care Center of Lancaster 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 Action for Targeted Residents</u>  The latches on Rooms 19, 9, N18, N20 and N24 were repaired by the Maintenance Department and were properly latching prior to the LSC exit on 2/5/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: SAM FRAZIER TITLE: ADMINISTRATOR (X6) DATE: 2/26/13

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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K 018	Continued From page 1 hazardous areas are substantial doors, such as those constructed of 1 1/4 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, the facility failed to ensure that corridor doors were maintained according to NFPA standards. This deficient practice affected three of six smoke compartments, staff, and approximately forty-five residents. The facility has the capacity for 100 beds with a census of 92 on the day of the survey.  The findings include:  During the Life Safety Code tour on 02/05/13 at 12:25 PM with the Director of Maintenance (DOM), a corridor door to resident room 19 would not latch. Corridor doors must close and latch to	K 018	<u>Identification of Other Residents with Potential to be Affected</u>  Residents have the potential to be affected by smoke in a fire situation if their doors do not properly latch. During the week of 2/11/13 – 2/15/13, the Director of Maintenance and Administrator completed an audit of every door in the facility to assure that doors properly close and latch completely. No other residents or doors were affected. Doors are in proper working order, resulting in no additional deficient practices.  <u>Systematic Changes</u>  Staff was re-educated prior to and on 2/28/13 by the Administrator and/or the Director of Maintenance on the facility's policy on completing maintenance request orders. The Director of Maintenance will also address this policy when he conducts his portion of orientation for any new hires. The Director of Maintenance will now be using this door latch audit tool as part of his monthly audits. In addition, assuring doors are completely shutting and properly latching has been added to the weekly Administrative Room Round Audits, which are copied to the Director of Maintenance. Any future repairs to the door latches will be completed by the Director of Maintenance as needed.	

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K 018	Continued From page 2 help resist the passage of smoke in a fire situation. During the survey resident rooms 9, N18, N20, and N24 also would not latch.  An interview on 02/05/13 at 12:25 PM with the DOM revealed he had been having trouble with the hinges and would repair the doors when he became aware of the doors not latching.  The findings were revealed to the Administrator upon exit.  Reference: NFPA 101 (2000 Edition).  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.	K 018	<u>Monitoring</u>  Maintenance issues are discussed every morning, Monday through Friday, during the facility's Stand-Up Meeting, which is presided over by the Administrator. Concerns reported are reviewed and addressed on a daily basis. On weekends, the charge nurses have been instructed to notify the Director of Maintenance of any emergency issues.  A door latching audit is to be completed monthly by the Director of Maintenance. Results of these audits will be presented monthly at the Performance Improvement Committee meeting for a period of 12 months as long as 100% threshold is met. This Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Consultant Pharmacist, Director of Maintenance, Dietary Supervisor, Social Services Director, Admissions Coordinator, MDS Coordinator, HR Director, Activities Director and Housekeeping/Laundry Supervisor.	
K 044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Horizontal exits, if used, are in accordance with 7.2.4. - 19.2.2.5  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the emergency generator set by NFPA standards. This deficient practice affected three of six smoke compartments, staff, and approximately forty-five residents. The facility has the capacity for 100 beds with a census of 92 on the day of the survey.	K 044		3/18/13

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
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K 044	<p>Continued From page 3</p> <p>The findings include:</p> <p>During the life safety code tour on 02/05/13 at 1:10 PM with the Director of Maintenance (DOM), the outside generator set revealed leaves embedded in the fan shroud and throughout the generator enclosure. This situation could inhibit the generator from operating as intended in an emergency situation.</p> <p>An interview with the DOM on 02/05/13 at 1:10 PM revealed leaves were removed from the generator enclosure recently but had returned.</p> <p>The Administrator was made aware of the findings upon exit.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction.</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established.</p>	K 044	<p><u>K044</u></p> <p>Christian Care Center of Lancaster 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 Action for Targeted Residents</u></p> <p>The leaves were removed from the generator fan shroud and the generator enclosure by the Maintenance Department prior to the LSC exit on 2/5/13.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current residents have the potential to be affected if the generators are not in proper working order. During the week of 2/11/13 – 2/15/13, the Director of Maintenance and Administrator updated the generator audit to include cleaning of the area of any leaves or debris. The generators are both in proper working order, resulting in no additional deficient practices.</p>	

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

PRINTED: 02/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2013
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
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