

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An abbreviated survey investigating KY 19788 was initiated on 02/19/13 and concluded on 02/20/13. The Division of Health Care substantiated the allegation with deficiencies cited.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provision of federal and state law.		
F 271 SS=E	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to obtain physician orders on admission for a BiPAP used for variable levels of air pressure and a CPAP machine used for continuous positive pressure to help get more air into the resident's lungs. Both machines were used to help treat breathing difficulties for two (2) of four (4) sampled residents and one (1) of one (1) unsampled residents. Residents #1, #4 and Unsampled Resident #5. The findings include: The facility did not provide a policy regarding physician orders. 1. Review of the clinical record for Resident #1, revealed the facility admitted the resident on 12/10/12-12/24/12, 12/27/12-12/29/12, 12/31/12-1/8/13, and 01/11/13-02/05/13 with diagnoses of Congestive Heart Failure, Chronic	F 271	F271 1. Resident #1 discharged from the facility on 02/05/13. Resident #4 and #5 had their orders reviewed by licensed nurses on 2/20/13 and will be verified by their attending physician by 04/04/13. 2. All other residents' current orders were reviewed by a licensed nurse by 3/1/13, and will be verified by their attending physician by 04/04/13. New residents admitted to the facility will have their admission orders checked by 2 licensed nurses to ensure accuracy. 3. Licensed staff were educated by the Staff Development Coordinator on 2/20/13 on admission policy and procedure. Staff Development Coordinator will educate all licensed nurses to complete admission orders with two licensed staff to ensure accuracy by 04/04/13. This in-service will also include medication reconciliation and the discharge summary. Any questions or discrepancies are to be verified with the attending physician. Any medical equipment brought to the facility on behalf of the resident is to have a physician's order for use. The Unit Manager will audit new admission orders for accuracy 3 times weekly for 4 weeks, then weekly for 4 weeks, then monthly. The Admission Policy and Procedure was reviewed and revised by the Director of Clinical Support on 2/20/13. A licensed nurse will audit resident rooms for equipment and correlating orders 1 time weekly for 4 weeks, then bi monthly for 3 months, monthly for 3 months, then as recommended by the Quality Assurance Committee.		

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

[Signature]

DATE

[Signature] 3/15/13

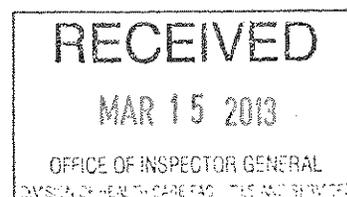
A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RECEIVED
MAR 15 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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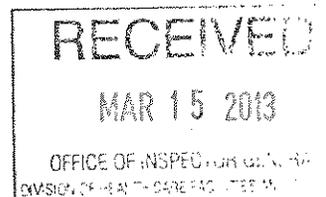
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F 271	<p>Continued From page 1</p> <p>Obstructive Pulmonary Disease, Pulmonary Fibrosis, and Obstructive Sleep Apnea. Resident #1 was hospitalized at a local hospital between those dates. An initial assessment was completed for Resident #1 and on each assessment it was noted the resident used a BiPAP or CPAP machine. There was not a physician order for BiPAP or CPAP for Resident #1 for any of those admissions.</p> <p>2. Review of the clinical record for Resident #4, revealed the facility admitted the resident on 01/29/13 with the diagnoses of Congestive Heart Failure, Pneumonia, and Obstructive Apnea. The initial assessment did not include the presence of the CPAP machine. An order for the CPAP was obtained on 02/08/13 and added to the assessment on 02/19/13.</p> <p>Interview with Resident #4, on 02/20/13 at 4:10 PM, revealed he/she had worn the C-PAP at night for seven years. A personal C-PAP was brought to the facility for use by Resident #4.</p> <p>3. Review of the clinical record for Unsampled Resident #5 revealed the facility admitted the resident on 02/07/13 with diagnosis of Chronic Obstructive Pulmonary Disease. The initial assessment completed on 02/07/13 indicated Unsampled Resident #5 had a CPAP machine. Review of the medical record revealed there was not a physician order at the time of admission; however, it was obtained on 02/19/13.</p> <p>Interview with Unsampled Resident #5, on 02/20/13 at 4:15 PM, revealed he/she had worn the C-PAP for four to five years and the one in the room belonged to him/her.</p>	F 271	<p>4. These audits will be reviewed by the Director of Nursing, and presented to the Quality Assurance committee monthly for further recommendations.</p> <p>Compliance 04/05/13</p>		



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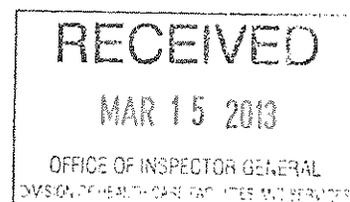
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F 271	Continued From page 2 Interview with LPN #1, on 02/20/13 at 10:07 AM, revealed if a resident was on a C-PAP or BIPAP there should be a physician's order, even if a resident brought their own machine from home, an order should be obtained from the physician. Interview with the Unit Manager, on 02/20/13 at 4:27 PM, revealed she thought nurses knew an order from a physician was required for the Bi-PAP and CPAP machines. She stated the machines for Residents #1, #4 and Unsampled Resident #5 were all brought in from home, but they still should have had a physician's order for the resident's use in the facility. Interview with the DON, on 02/20/13 at 10:07 AM, revealed an order should be obtained for residents on C-PAP or BiPAP machines. She was not aware there were no orders for Residents #1, #4 and Unsampled Resident #5. She stated each machine had specific settings for the specific resident to ensure the resident was getting the breathing help they needed. The need for the order was to ensure those machines are set correctly.	F 271		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		



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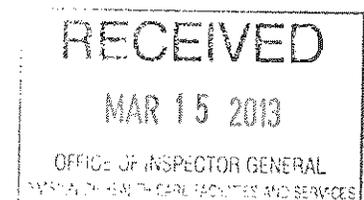
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F 279	<p>Continued From page 3 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to develop a comprehensive plan of care for one (1) of four (4) sampled residents and one (1) unsampled resident. Resident #1.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans, not dated, revealed all residents would have care plans. The purpose of the care plan was to provide guidance to all staff caring for the resident and communicate changes in care to all direct care staff.</p> <p>Review of the facility care plan meeting form letter, sent to responsible party of residents, revealed the first care plan was held within three weeks of a resident's admission to the facility; however, the letter was amended with handwriting changing the word three to a two, and signed by Social Services.</p>	F 279	<p>F279</p> <ol style="list-style-type: none"> 1. Resident # 1 has discharged from the facility 02/05/13. 2. All resident comprehensive care plans were reviewed and revised by 03/08/13 as needed by a licensed nurse. 3. The letter inviting the resident and responsible parties of the resident was revised by the Social Services Director and approved by the Administrator on 03/14/13. <p>The interdisciplinary team consisting of the Unit Manager, Dietary Manager, Activity director and Social Services Director will be in-serviced by the Director of Clinical Operations to complete a comprehensive care plan for residents within 7 days of completion of the comprehensive assessment by 3/22/13.</p> <p>The Unit Manager, Staff Development Coordinator and/or Medical Records clerk will audit 50% of resident's records for completion of a comprehensive care plan that were scheduled for a Comprehensive Assessment weekly for 4 weeks, then 25% for 4 weeks, then 10% thereafter or as recommended by the Quality Assurance Committee.</p> <ol style="list-style-type: none"> 4. These audits will be reviewed by the Director of Nursing and Administrator, and then presented to the Quality Assurance committee monthly for further recommendations. <p>Compliance 04/05/13</p>	



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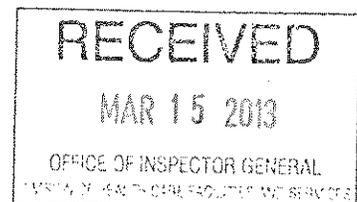
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F 279	<p>Continued From page 4</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 01/11/13 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis, Hypertension, Chronic Kidney Disease, and Obstructive Sleep Apnea. Resident #1 had stays at the facility from 12/10/12-12/24/12, 12/27/12-12/29/12, 12/31/12-1/8/13, and 01/11/13-02/05/13. Resident #1 was hospitalized at a local hospital between those dates. An initial Resident Assessment Instrument (RAI) was completed on 12/17/12, from the first admission. The comprehensive care plan was due on 12/24/12. There was no comprehensive care plan developed within seven days after the completion of that assessment, as required. An initial assessment was completed on 01/11/13, for the last admission and an interim care plan was initiated. A comprehensive care plan was due on 01/18/13, addressing the areas of concern identified on the Care Area Assessment; however the care plan was never completed.</p> <p>Attempted interview with the MDS Coordinator, on 02/20/13 at 1:45 PM, revealed she was not available via phone and a voice message was left to contact the facility, as of exit no response was received.</p> <p>Interview with the Director of Nursing (DON), on 02/20/13 at 11:10 AM, revealed care plans were initiated at the time of initial assessment. The care plan was good for twenty days, after twenty days a new care plan was generated from the computer or the initial care plan was updated and it became the comprehensive care plan. The DON reviewed Resident #1's medical record and</p>	F 279		



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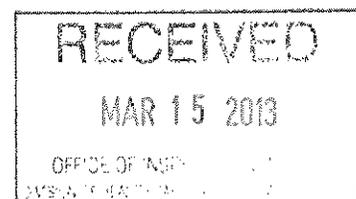
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F 279	Continued From page 5 stated there was no comprehensive care plan in the record. She stated the care plan needed to be accurate because it directed the care provided to a resident. Interview with the Administrator, on 02/20/13 at 11:37 AM, revealed normally as part of the initial assessment, an initial care plan was initiated. The full comprehensive assessment was completed by day 21. The initial care plan could be converted to a comprehensive care, but that did not happen for Resident #1.	F 279	F280 1. Resident #1 has discharged from the facility on 02/05/13. 2. On 03/14/13, Current residents of the facility were placed on a calendar to ensure an invitation is sent to the responsible party and the resident to attend a care conference within 7 days of completion of the comprehensive assessment and quarterly. New residents admitted will be placed on the calendar upon admission. The responsible party will be given an initiation during completion of the admission process to attend the first care conference.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	3. The letter inviting the resident and responsible parties of the resident was revised by the Social Services Director and approved by the Administrator on 03/14/13. The care plan calendar was reviewed by the Social Services Director on 03/14/13. The Social Services Director was educated by the Administrator on 3/15/13 to invite residents and the responsible party to the care conference based on the care plan calendar. The Administrator will audit the Care Plan Invitation Log weekly for 4 weeks, bi-monthly for 2 months, monthly for 2 months, then as recommended by the Quality Assurance Committee. 4. These audits will be presented to the Quality Assurance committee monthly for further recommendations. Compliance 04/05/13	



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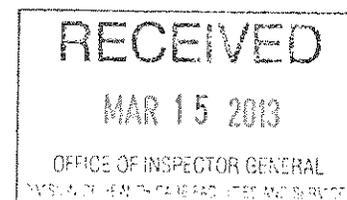
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F 280	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to notify the responsible party of a care plan meeting for one (1) of four (4) sampled residents and one (1) unsampled resident. Resident #1.</p> <p>The findings include:</p> <p>Review of the facility policy regarding Care Plans, not dated, revealed the resident and responsible party will be encouraged to attend the conference or will be made aware of the information and input requested as necessary. Care plans are usually more workable and realistic if there is input from the resident, the direct care staff and each department involved in the care. Responsible party/resident invitation to attend care conferences will be documented.</p> <p>Review of a care plan meeting form letter, sent to the responsible party of a resident, revealed the first care plan meeting was held within three weeks of the resident's admission; however, the letter had been revised by handwriting a two above the word three and signed by Social Services.</p> <p>Interview with Family Member #1, on 02/18/13 at 1:41 PM, revealed he/she was never notified of a care plan meeting with the staff at the facility. Family Member #1 stated he/she wanted the opportunity to discuss some areas of concern regarding the care provided for Resident #1.</p> <p>Interview with the Director of Social Services, on</p>	F 280	



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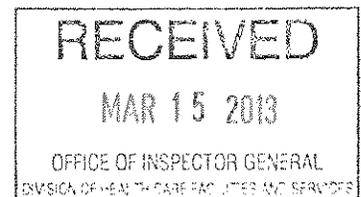
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F 280 F 309 SS=D	<p>Continued From page 7</p> <p>02/20/13 at 12:22 PM, revealed she had only been at the facility since 02/01/13. She stated there were no records from the previous DSS. She did not know when or if any letters had been sent to Family Member #1 regarding a care plan meeting.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to follow physician orders for one (1) of one (1) unsample resident and four (4) sampled residents. The facility failed to administer a physician ordered medication (Colace) to Unsampled Resident #5 twice a day, instead gave it once a day for thirteen (13) days.</p> <p>The findings include: The facility did not provide a policy regarding transcribing medication orders. Review of the clinical record for Unsampled</p>	F 280 F 309	<p>F309</p> <ol style="list-style-type: none"> 1. Resident # 5 will have his orders reviewed and verified as correct by the attending physician by 04/04/13. 2. All other residents' current orders were reviewed by a licensed nurse by 3/1/13, and will be verified by their attending physician by 04/04/13. 3. Staff Development Coordinator began in-servicing License staff on 02/20/13 to recheck MARs after medication pass to insure all medications have been given and documented. All Licensed staff will be in-serviced by 3/22/13. <p>The Wound Nurse, Unit Manager and/or Staff Development Coordinator will audit MARs and TARs for completed documentation of medication and treatments ordered one time daily five times a week for four weeks, one time daily one time per week for four weeks, then as recommended by the quality assurance committee. These audits will be reviewed by the Director of Nursing with the Nursing Home Administrator.</p> <ol style="list-style-type: none"> 4. These audits will be presented to the Quality Assurance committee monthly for further recommendations. <p>Compliance 04/05/13</p>	



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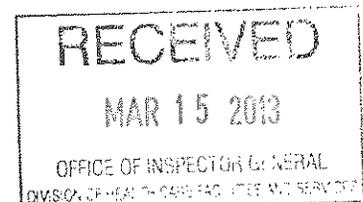
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F 309	Continued From page 8 Resident #5 revealed the facility admitted the resident on 02/07/13 with the diagnosis of Chronic Obstructive Pulmonary Disease. The initial orders included an order for Colace, 100mg, twice a day. The order was written on the Medication Administration Record (MAR) as Colace, 100mg, twice a day. The medication was initialed as given once a day for 13 days from the day of admission. Interview with the Unit Manager, on 02/20/13 at 4:27 PM, revealed nurses should always read an order before giving medications. The nurse should check the order for the correct medication, the correct time, the correct dose and the correct route. If there was a discrepancy the nurse should call the MD to get clarification and make sure the resident was okay. They would also notify the UM and start an incident report. When any resident was admitted to the facility, the nurse would initiate facility orders from the discharge orders recieved from the hospital and then call the MD to verify the orders. The next day either the UM or the DON would review the orders and the care plan to ensure all orders were correct. She stated she guessed whomever reviewed the orders on Unsampled Resident #5 just missed the incorrect Colace order.	F 309			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431			



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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 MAGAZINE STREET LOUISVILLE, KY 40203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 9 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to maintain treatment carts in a safe manner. There were three (3) of three (3) treatment carts left unlocked and unattended. The findings include: Review of the facility's policy regarding Medication Storage in the Facility, not dated,</p>	F 431	<p>F431 .</p> <p>1. and 2. All residents have the ability to be affected.</p> <p>3. Licensed staff will be educated by the staff development coordinator to secure medications and treatments from resident access by 03/29/13.</p> <p>Staff Development Coordinator or Nurse Management will audit medication and treatment carts to insure they are secure three times weekly for four weeks, then one time weekly for four weeks and one time monthly or as recommended by the Quality Assurance Committee. These audits will be reviewed by the Director of Nursing with the Nursing Home Administrator.</p> <p>4. These audits will be presented to the Quality Assurance committee monthly for further recommendations.</p> <p>Compliance 04/05/13</p>	



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

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F 431	<p>Continued From page 10</p> <p>revealed medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.</p> <p>Observation during the initial tour of the facility, on 02/18/13 at 10:53 AM, revealed the treatment carts on Evergreen Court, Lakeview Avenue and Maple Boulevard were left unlocked and unattended. The three carts were unattended in the hallway and no staff were within sight of the carts.</p> <p>Interview with LPN #2, on 02/20/13 at 10:55 AM, revealed Medication and Treatment carts should be locked when someone was not with them. She stated if the carts were left unlocked and unattended a resident could get into the cart and use something improperly.</p> <p>Interview with the DON, on 02/20/13 at 1:37 PM, revealed medication and treatment carts should be locked when not in use or not in direct view of the nurse. It was necessary to keep unauthorized people from having access to the cart and what was inside the cart. She stated all staff knew those carts were to be kept locked for safety.</p>	F 431		

