

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

PRINTED: 09/22/2015
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 R 09/20/2015
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203
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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

Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/20/15 as alleged.

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185468	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/20/2015
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Name of Facility CHRISTIAN HEALTH CENTER - WEST, INC	Street Address, City, State, Zip Code 1015 MAGAZINE STREET LOUISVILLE, KY 40203
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(i)</u> LSC _____	Correction Completed <u>09/20/2015</u>	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(ii)</u> LSC _____	Correction Completed <u>09/20/2015</u>	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed <u>09/20/2015</u>
ID Prefix <u>F0322</u> Reg. # <u>483.25(q)(2)</u> LSC _____	Correction Completed <u>09/20/2015</u>	ID Prefix <u>F0371</u> Reg. # <u>483.35(i)</u> LSC _____	Correction Completed <u>09/20/2015</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>09/20/2015</u>
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>MZ</u> State Agency	Reviewed By <u>VT</u>	Date: <u>09/22/15</u>	Signature of Surveyor: <u>Millic Zornstein</u>	Date: <u>9/22/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>8/20/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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F 000	INITIAL COMMENTS	F 000	The provider wishes this plan to be considered as our allegation of compliance. Preparation and 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 this statement of deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop an initial care plan for one (1) of seventeen (17) sampled residents, Resident #11. The facility admitted Resident #11 on 08/12/15 and an initial care plan was not developed for the resident's Contact Precautions.</p> <p>The findings include:</p> <p>Review of the facility's policy for Care Planning, dated 10/30/14, revealed the admitting nurse and/or Nurse Manager initiated a care plan to reflect the resident's current needs. Licensed nurses would updated the initial care plan with any changes in care until the comprehensive care plan was completed.</p> <p>Review of the clinical record for Resident #11 revealed the facility admitted the resident on 08/12/15 with diagnoses of Congestive Heart Failure, Cough, Diabetes, Shortness of Breath, and Chronic Obstructive Pulmonary Disease.</p>	F 281			

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

TITLE

(X6) DATE

[Signature]
Administrator

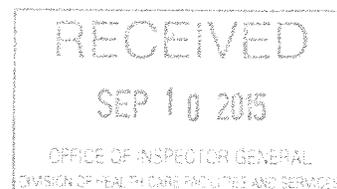
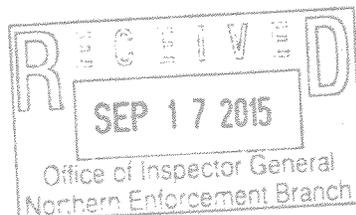
9/9/2015

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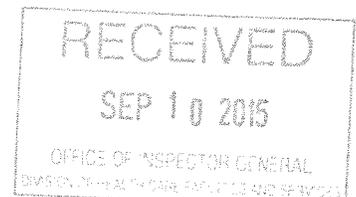
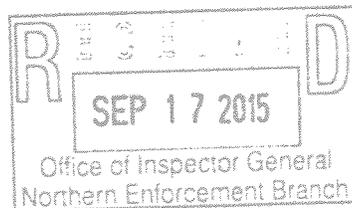
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F 281	<p>Continued From page 1</p> <p>Review of the initial care plan, dated 08/13/15, revealed the resident was a fall risk, had chronic pain, received oxygen at all times and needed the head of the bed and legs elevated. The resident was monitored for shortness of breath and food intake. There was no documented evidence the resident's care plan included the resident's contact/droplet precautions.</p> <p>Review of the Resident Summary Assessment (nurse aide care plan), dated 08/13/15, revealed no documented evidence that isolation precautions were addressed.</p> <p>Observation of Resident #11, on 08/18/15 at 9:10 AM, revealed the resident's door was closed and a sign was posted on the door for visitors to see the nurse prior to entry. A small portable cabinet was placed outside of the resident's door with masks, gowns, gloves and trash bags inside.</p> <p>Interview with the Director of Nursing, on 08/18/15 at 9:10 AM, during the initial facility tour, revealed the resident was admitted on contact precautions for Methicillin Resistant Staphylococcus Aureous (MRSA) infection in the nose/sputum.</p> <p>Interview with CNA #2, on 08/18/15 at 9:45 AM, revealed Resident #11 was in contact precaution for MRSA in the nose. She stated there were no interventions on the care plan for how to care for the resident. She stated everyone was wearing a mask and gloves to prevent spreading of infection.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 08/20/15 at 1:20 PM, revealed the admission care plan was initiated by the admission nurse</p>	F 281	<p>1) Resident #11's ARNP removed the resident from isolation on 8/22/15. In addition, Resident #11's comprehensive care plan was reviewed to assure accuracy of current care needs. DON completed this review.</p> <p>2) Only one other resident, Resident #12, remained in isolation precautions as of 8/20/15. New signage indicating contact isolation precautions and the appropriate personal protective equipment (PPE) was placed onto the door of Resident #12's room on 8/20/15. Resident #12's care plan was updated on 8/20/15 and 8/24/15 to reflect current isolation precautions (Attachment #1). No other residents in the facility remained in isolation precautions. DON completed this.</p> <p>3) It is the practice of the facility to incorporate isolation precautions into the plan of care when indicated. On 8/20/15, the licensed nursing staff were</p>
8/22/2015	8/20/2015	8/20/2015	



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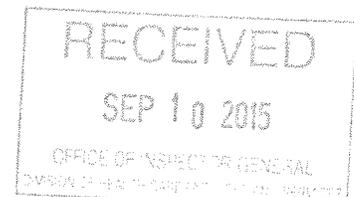
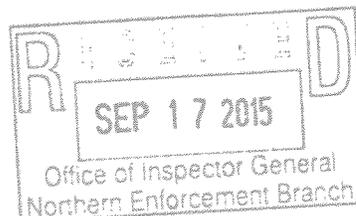
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F 281	Continued From page 2 and updated by nurses as needed. She stated she could not find the care plan in the computer and did not know if isolation was addressed. Interview with the Director of Nursing, on 08/20/15 at 3:06 PM, revealed gowns were to be worn when entering a contact precaution room. She stated the resident summary assessment for Residents #11 should include instructions for each resident's care, including contact isolation.	F 281	re-educated by the Director of Nursing on the correct isolation precaution procedures (Attachment #2). In addition, the Staff Development Coordinator will educate all facility staff on infection control practices including updating a resident's plan of care and resident summary. Infection control practices training was already included in the facility's general orientation. This orientation has been expanded to include more information on different types of isolation precautions and their respective PPE usage (Attachment #3) as well as the updating of care plans. Moreover, new isolation precaution signage was implemented that better notify the staff of the type of isolation precaution and PPE that are required (Attachment #4). Lastly, QAPI indicators have been	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, and review of the facility's policy, it was determined the facility failed to follow the care plan for two (2) of seventeen (17) sampled residents. (Residents #4 and #5). Resident #4 had a diagnosis of Dysphagia and required the head of the bed to be elevated thirty (30) degrees. In addition, the resident had a recent history of falls and was to be seated in a recliner in the common area by the nursing station when not in bed or receiving care. Resident #5 received pain medication that was not ordered by the physician. The findings include: Review of the facility policy for Following the Care	F 282		



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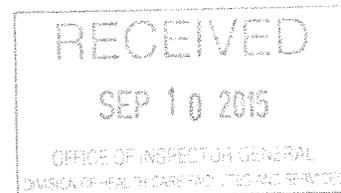
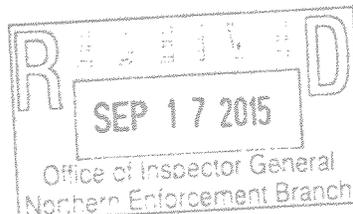
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F 282	Continued From page 3 Plan, dated May 2014, revealed the Resident Summary Assessment was on the computer and provided nurse aides with information on the residents' care. 1. Review of the clinical record revealed the facility admitted Resident #4, on 12/19/15, with diagnoses of Dementia, Bipolar Disorder, Schizoaffective Disorder, Diabetes, and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/15/15, for Resident #4, revealed the resident was not interviewable with a Brief Interview for Mental Status (BIMS) score of four (4) out of possible fifteen (15). The resident required extensive assistance of one with activities of daily living, was incontinent of bowel and bladder and had a high fall risk. The resident received all nutrition through a Gastrostomy Tube. Review of the care plan for Resident #4, dated 07/08/15, revealed the resident was at high risk for falls and had a recent history of falls. Interventions included placing the resident in a recliner in the common area with an alarm when out of bed or not receiving care. In addition, the resident had penetration and silent aspiration and the head of the bed was to be elevated to thirty (30) degrees. Review of the Resident Summary Assessment (nurse aide care plan) for Resident #4, revealed the resident was to be in the common area in a recliner with a tab alarm when not in bed or receiving care. In addition, the head of the bed was to be elevated thirty (30) degrees when the resident was in bed.	F 282	added to the facility's existing QAPI program which already included infection control monitoring. These indicators include the Staff Development Coordinator auditing 100% of residents with isolation precautions for infection control compliance and verification of an updated plan of care and resident summary (Attachment #5). The Staff Development Coordinator will provide an audit report monthly to the Director of Nursing. 4) The Director of Nursing will provide an audit report to the QAPI Committee on a monthly basis for at least 12 months Compliance Date: 9/20/2015	



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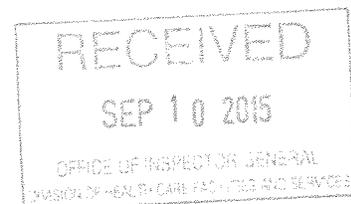
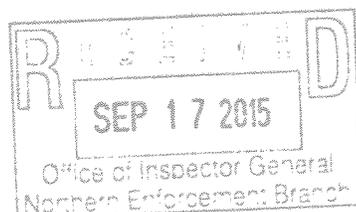
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F 282	<p>Continued From page 4</p> <p>Observation of Resident #4, on 08/18/15 at 12:45 PM, 2:30 PM, 3:14 PM and on 08/19/15 at 11:15 AM, 1:00 PM and 2:15 PM, revealed the resident seated in a chair in his/her room.</p> <p>Observation of Resident #4, on 08/18/15 at 11:17 AM, and on 08/19/15 at 7:26 AM, 8:15 AM and 9:20 AM, revealed Resident #4 in bed with the head of the bed flat.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 08/19/15 at 9:22 AM, revealed she was not sure what the resident's care plan stated regarding where the resident was to be seated when out of bed. She stated she did not take the resident to the common room when out of bed. She indicated she placed the resident in a chair at the bedside with a tab alarm so she could watch the resident. She stated she forgot to raise the resident's head to prevent choking. She stated the resident's care plan (resident summary assessment) was available in the computer, however, she had not reviewed it recently. She stated she was trained by the facility to follow the resident's care plan.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 08/20/15 at 1:20 PM, revealed she was not able to locate the care plan for Resident #4 in the computer. She stated she was responsible for supervising resident care; however, she was unable to provide information on the resident's plan to prevent falls. She stated the resident had a feeding tube and the resident's head should be elevated and not flat. She stated the bed being flat placed the resident at risk for aspiration.</p> <p>Interview with the Director of Nursing, on</p>	F 282	<ol style="list-style-type: none"> 1) Resident #4's plan of care did indicate that the resident's head was to be elevated and to be moved to the common area when out of bed. Education was provided to the caregiver by the Director of Nursing on 8/20/15. Resident #5 was assessed by the RN Nurse Consultant on 8/27/15 and no adverse symptoms were noted. The additional doses of medication were reported to Resident #5's physician by the Director of Nursing on - 8/23/15. 2) All residents with enteral feeding care plans or resident summaries were reviewed on 8/24/15 by the RN Nurse Consultant. In addition, controlled medication records were reviewed by the RN Nursing Consultant on 8/24/15 to ensure the plan of care for each resident was implemented. 3) The facility follows the standards of nursing



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F 282	Continued From page 5 08/20/15 at 3:10 PM, revealed all nursing staff were trained to use the care plan to provide care for residents. She stated the Resident Summary Template for each resident was in the computer and provided nurse aides with the information needed to provide care. She stated residents with G-tubes were not to be flat in bed and were to have the head of the bed elevated to prevent aspiration. She stated Resident #4 had several falls and needed to be in an area where more supervision was available to prevent falls. 2. Review of the clinical record revealed the facility admitted Resident #5 on 05/22/15 for rehabilitation following a Below Knee Amputation of the right leg. Review of the Admission Minimum Data Set (MDS) assessment, dated 05/29/15, revealed Resident #5 experienced pain and had struggled with pain management since his/her surgery. The facility administered a Brief Interview for Mental Status (BIMS) that revealed a score of fifteen (15) out of possible fifteen (15), indicating no cognition impairment and the resident was interviewable. Review of the care plan for Resident #5, dated 06/17/15 revealed the resident experienced pain and possible interventions included administering pain medications as ordered, observe for pain, reposition to decrease pain, observe for non-verbal symptoms of pain and monitor any pain that interfered with activities of daily living or sleep. Review of the physician order, dated 07/08/15,	F 282	practice and provides care in accordance to the physician's orders and the resident's plan of care. The interim Director of Nursing will conduct education for all nurses on "Proper Administration of Controlled Medications" which includes following the plan of care (Attachment #6). The Staff Development Coordinator will conduct education on "Proper Care of Residents With Enteral Feeding and Following the Plan of Care" (Attachment #7). These education topics have been included in the facility's nursing orientation (Attachment #3). In addition, QAPI indicators have been added to the facility's existing QAPI program to monitor proper administration of controlled medications and proper care of enteral feeding. The Director of Nursing will randomly sample 50% of controlled	



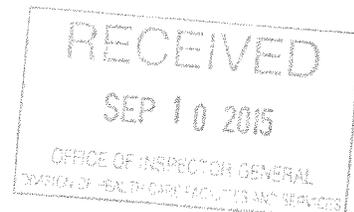
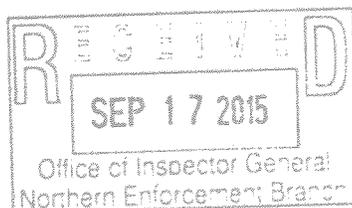
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F 282	<p>Continued From page 6</p> <p>revealed the physician had ordered Hydrocodone-Acetaminophen (Norco) 7.5/325 MG one (1) tablet to be administered two (2) times daily, as needed for pain.</p> <p>Review of the Controlled Drug Record, dated 07/14/15, revealed Resident #5 received four (4) doses of Norco on 07/28/15 .</p> <p>Review of the Controlled Drug Record, dated 07/27/15, revealed the resident received three (3) doses of Norco on 07/31/15 and 08/19/15. Refer to F309.</p> <p>An interview with LPN #2, on 8/20/15 at 1:45 PM and 2:31 PM, revealed she administered a late dose of Norco on the evening of 07/28/15. She stated she thought the resident was getting the pain medication every four (4) hours at that time. After reviewing the MD order, which appeared in the bottom right hand corner of the Controlled Drug Record, LPN #2 stated she had administered the pain medication at the date and time indicated on the record.</p> <p>A telephone interview with LPN #2, on 08/20/15 at 2:28 PM, revealed she did not remember giving Resident #5 additional medication, but if she signed and dated the Controlled Drug Record, she administered the medication at the date and time indicated.</p> <p>An interview with the DON, on 08/20/15 at 1:40 PM, revealed upon review of the physician's order and the Controlled Drug Record, which covered a thirty (30) day period, revealed Resident #5 received more pain medication than was ordered</p>	F 282	<p>medication orders for proper administration on a monthly basis (Attachment #8). The Director of Nursing will also review a 100% sample monthly of all enteral feeding orders to verify proper care and documentation (Attachment #9). Lastly, the Director of Nursing will review a 10% sample of resident care plans monthly to ensure that the care plan is being implemented (Attachment #10)</p> <p>4) The Director of Nursing will provide an audit report to the facility's already existing QAPI Committee on a monthly basis for at least 12 months.</p> <p>Compliance Date: 9/20/2015</p>	

F282: Additional Detail- 9/15/15-

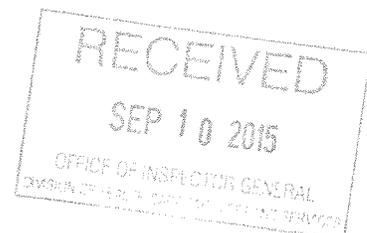
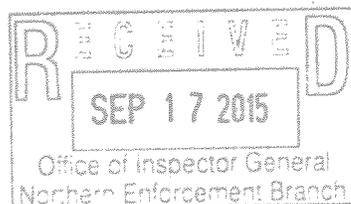
The SDC and DON conducted inservice training for all nursing personnel on proper tube feeding protocols on 9/9/15, 9/10/15, and 9/17/15.



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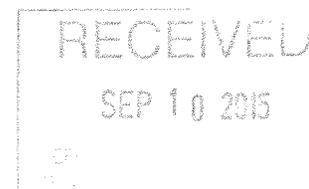
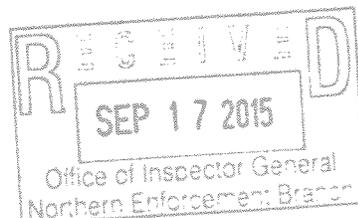
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2015	
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203		
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F 282	Continued From page 7 by his/her physician for four (4) days.	F 282		
F 309 SS=D	<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 observation, interview, record review and review of the facility's policies and procedures, it was determined the facility failed to administer medication per the physician's order for one (1) of seventeen (17) sampled residents, Resident #5. On 07/08/15, the physician ordered Hydrocodone-Acetaminophen (Norco) 7.5/325 MG tablets to be administered to Resident #5 two (2) times daily as needed for pain (PRN). However, the staff failed to administer the medication as ordered on four (4) days, 07/28/15, 07/31/15, 08/15/15 and 08/19/15 of the thirty (30) days reviewed.</p> <p>The findings include: Review of the facility's policy titled Medication Orders, dated 03/02/15, revealed medications</p>	F 309	<p>1) Resident #5 was assessed by the RN Nurse Consultant on 8/27/15 and no adverse symptoms were noted. The additional doses of medication were reported to Resident #5's physician by the Director of Nursing on 8/23/15.</p> <p>2) All active, controlled medication records were reviewed for irregularities by the RN Nurse Consultant to determine if any other residents were affected. This assessment was completed on 8/24/15.</p> <p>3) The facility follows the standards of nursing practice and provides care in accordance to the physician's orders and the resident's plan of care. The interim Director of Nursing will conduct education for all nurses on "Proper</p>	<p>8/23/2015</p> <p>8/24/2015</p> <p>9/20/2015</p>



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F 309	Continued From page 8 were to be administered only upon the clear, complete and signed order of a person lawfully authorized to prescribe. Review of Resident #5's clinical record revealed the facility admitted the resident on 05/22/15 for rehabilitation following a Below the Knee Amputation of the right leg. The following diagnoses were present upon admission: Anemia, Renal Failure, Diabetes Mellitus Type II, Hepatitis C, Diabetic Retinopathy, and a History of Cerebrovascular Accidents. The resident received Hemodialysis three (3) times a week. Review of the admission Minimum Data Set (MDS) assessment, dated 05/29/15, revealed Resident #5 experienced pain and had struggled with pain management since his/her surgery. The facility administered a Brief Interview for Mental Status (BIMS) that revealed a score of fifteen (15) out of possible fifteen (15), indicating no cognitive impairment. Review of the physician orders, dated 07/08/15, revealed the physician had ordered Hydrocodone-Acetaminophen (Norco) 7.5/325 MG (1) tablet to be administered two (2) times daily as needed for pain. Review of the Controlled Substance (Drug) Record, dated 07/14/15, revealed Resident #5 received four (4) doses of Norco on 07/28/15. Licensed Practical Nurse (LPN) #3 administered the third dose of the pain medication and LPN #2 administered the fourth dose. An interview with LPN #3, on 08/20/15 at 3:45 PM, revealed she did not remember giving	F 309	Administration of "Controlled Medications" which includes following the plan of care (Attachment #6). This education topic has been included in the facility's nursing orientation (Attachment #3). In addition, a QAPI indicator has been added to the facility's existing QAPI program to monitor proper administration of controlled medications. The Director of Nursing will randomly sample 50% of controlled medication orders for proper administration on a monthly basis (Attachment #8). 4) The Director of Nursing will provide an audit report to the facility's already existing QAPI Committee on a monthly basis for at least 12 months. Compliance Date: 9/20/2015	



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F 309

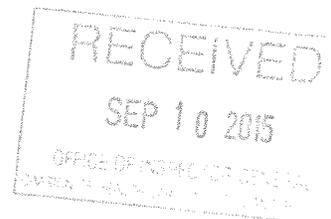
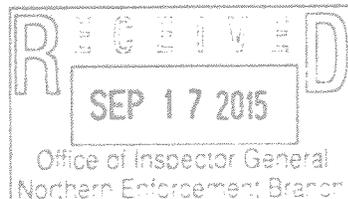
Continued From page 9
Resident #5 additional pain medication. She stated she thought the pain medication was scheduled for every six (6) hours as needed for pain, not twice a day. She stated that sometimes the medication orders are changed without the staff nurses knowledge. She stated she always documented in the digital Medication Administration Record (MAR) when she gave a PRN pain medication because it offered a special screen giving the seven (7) symptoms of pain for assessment. After reviewing the physician's order for the pain medication, which was included on the bottom right hand corner of the Controlled Drug Record, and validated her signature, LPN #3 stated that she had given the third dose of the Norco and could not account for why she didn't record it on the digital MAR.

Interview with LPN #2, on 08/20/15 at 1:45 PM, revealed she recalled giving Resident #5 the late dose of Norco on the evening on the 28th. She stated she recalled the 5:00 PM dose had been given, but didn't recall the 8:30 AM dose and thought the resident was still receiving the pain medication every four (4) hours/PRN. After reviewing the physician's order on the Controlled Drug Record and validating her signature and date, LPN #2 stated she had given an extra dose of the Norco that had not been ordered and could not account for why she didn't chart it on the digital MAR. A telephone interview with LPN #2, on 08/20/15 at 2:28 PM, revealed she did not recall administering the extra dose of pain medication to Resident #5 on 08/19/15; however, she stated if she signed and dated the Controlled Drug Record that day she had administered the medication as indicated.

F 309

F309: Additional Detail- 9/15/2015

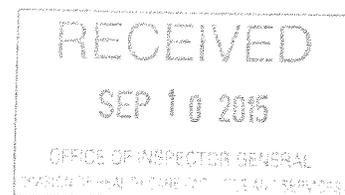
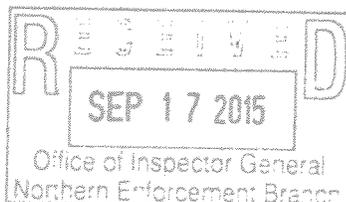
Inservices for controlled substance medication administration were performed by the SDC, with assistance from the interim DON on 9/9/15, 9/10/15 and 9/17/15.



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F 309	<p>Continued From page 10</p> <p>Continued review of the Controlled Drug Record revealed Resident #5 received three (3) doses of Norco on 07/31/15, 08/15/15, and 08/19/15. The Controlled Drug Record revealed LPN #1 administered the third dose of Norco to Resident #5 on 07/31/15 and 08/15/15.</p> <p>A telephone interview with LPN #1, on 08/20/15 at 2:31 PM, revealed she could not recall administering Resident #5 additional pain medication. She said she remembered Resident #5 experienced pain a lot and had difficulty with pain management shortly after the resident's surgery, but didn't think the resident experienced that much pain recently. However, she stated if her signature was on the Controlled Drug Record, she had administered the pain medication at the date and time indicated.</p> <p>Observation of Resident #5, on 08/19/15 at 8:45 AM, revealed the resident sitting up in his/her wheelchair in the common area waiting on a visitor before leaving for dialysis. Interview with the resident revealed the resident continued to struggle with pain management and despite having asked for additional pain medication he/she had not received more than two doses of Norco daily since the pain prescription dose changed on 07/08/15.</p> <p>Interview with the Director of Nursing (DON), on 08/20/15 at 1:40 PM, revealed that upon her review of the physician's orders and the Controlled Drug Record, which covered a thirty (30) day period, she found the resident had received more pain medication than was ordered</p>	F 309	



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F 309 Continued From page 11
by the resident's physician for at least four (4) days. Upon reviewing the digital MAR the DON reported the extra doses of pain medications were not recorded there. She stated if the nurse had attempted to record the additional doses, the computer software would have prevented those entries by displaying a red pop up screen indicating the timeframe remaining for the next ordered dose. The DON stated that it was the facility's policy for nurses to enter all administered medications into the electronic medical record. She continued to state that the shift to shift Narcotics count compared the Controlled Drug Record against the Narcotic medication available. There was no system to compare the digital MAR to the Controlled Drug Record or the digital MAR to the medication blister packages.

F 309

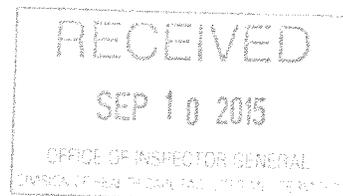
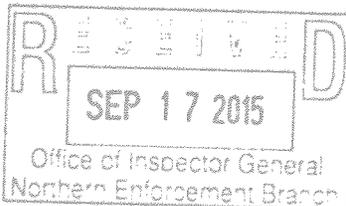
The DON expressed concern that Resident #5 received additional pain medication because the resident had End Stage Renal Disease and could not process additional medication. She stated the additional pain medication could cause the resident to become drowsy, increase respiratory distress, increase risk for falls or cause further injury to the resident's kidneys.

Interview with the Medical Director, on 08/20/15 on 4:15 PM, revealed he should be called anytime a resident had been given more medication than prescribed. He couldn't recall receiving any calls regarding the additional doses that Resident #5 had been administered.

F 322 483.25(g)(2) NG TREATMENT/SERVICES -
SS=D RESTORE EATING SKILLS

F 322

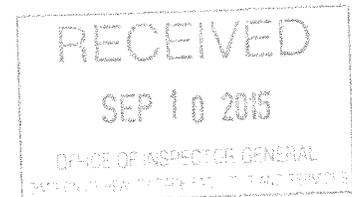
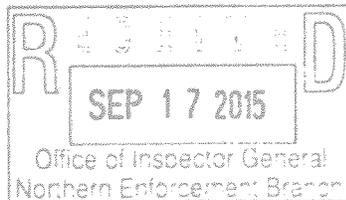
Based on the comprehensive assessment of a resident, the facility must ensure that --



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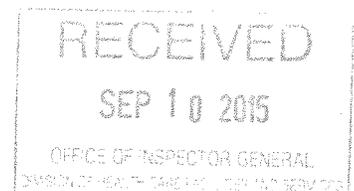
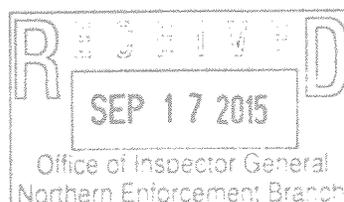
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F 322	<p>Continued From page 13</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/18/15, and completed by the facility, revealed the resident had a Brief interview for Mental Status score of 04/15 and was not interviewable. The resident required extensive assistance with all activities of daily living and was incontinent of bowel and bladder. The resident received all nutrition through a gastric tube.</p> <p>Review of the care plan, dated 07/08/15, for Resident #4, revealed the resident had a diagnosis of dysphagia and received tube feedings for all nutrition. The head of the bed was elevated, at least, thirty (30) degrees when the resident was in bed.</p> <p>Review of the Resident Summary Assessment, (nurse aide care plan), dated 07/08/15, revealed the resident was to be elevated, at least, thirty (30) degrees, when in bed.</p> <p>Observation of Resident #4, on 08/18/15 at 11:17 AM and on 08/19/15 at 7:26 AM, 8:15 AM and 9:20 AM, the resident was in bed with eyes closed and the head of the bed was flat. No care was observed to be in progress during these times.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 08/19/15 at 9:22 AM, revealed she forgot to elevate the bed for Resident #4. She stated she had been trained to elevate the head of the bed for residents on gastric tube feedings. She stated the resident could choke if the bed was flat.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 08/20/15 at 1:20 PM, revealed Resident #4 had a gastric tube and received gastric tube</p>	F 322	<p>education on "Proper Care of Residents With Enteral Feeding and Following the Plan of Care" (Attachment #7) to all nursing staff. This education topic has been included in the facility's nursing orientation (Attachment #3). In addition, a QAPI indicator has been added to the facility's existing QAPI program to monitor the proper care of enteral feeding. The Director of Nursing will review a 100% sample monthly of all enteral feeding orders to verify proper care and documentation (Attachment #9-).</p> <p>4) The Director of Nursing will provide an audit report to the facility's already existing QAPI Committee on a monthly basis for at least 12 months.</p> <p>Compliance Date: 9/20/2015</p>	9/17/2015



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F 322	Continued From page 14 feedings for nutrition. She stated the resident's head of bed should be elevated to prevent aspiration. She stated she supervised the CNAs on the unit and did not notice the resident's head was flat. Interview with the Director of Nursing, on 08/20/15 at 3:06 PM, revealed all nursing staff were trained to elevate the head of beds when residents received tube feedings. She stated failure to do so could result in aspiration in residents.	F 322	F322 Additional Detail: 9/15/2015- Resident #4 was assessed for s/s of aspiration with no adverse results. MD notified by DON on 8/25/15. DON, Unit Manager, and/or charge nurse will insure HOB is elevated and document on TAR. The results of this 100% audit of TAR will be reported to the QAPI Committee on a monthly basis for 6 months and then quarterly, thereafter.
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the kitchen's cleaning schedule, and it was determined the facility failed to prepare and serve food under sanitary conditions. Observation of the ice machine revealed streaks of a white substance on the door, ice on the freezer floor, a dirty vent hood over the stove top and fryer, a dark brown sticky substance on the fryer, and a brown sticky substance on the toaster.	F 371	1) The Food Service Director assured that the items noted in the survey report were cleaned and/or repaired on 8/22/15. 2) The facility only has one production kitchen that provides meals for all residents. 3) A revised cleaning schedule was implemented on 9/1/15 (Attachment #11). The Food Service Director will monitor and assure completion of this revised schedule. In addition, a QAPI indicator was established for the Food Service Director to conduct a weekly audit of the ice machine, freezer, fryer,



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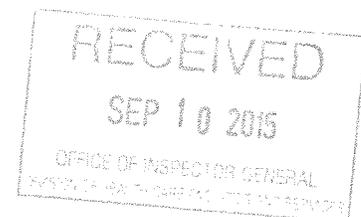
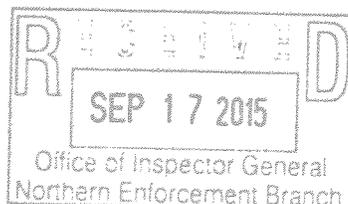
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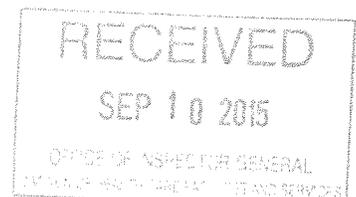
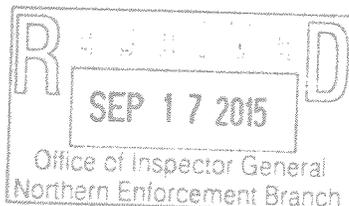
F 371	<p>Continued From page 15</p> <p>The findings include:</p> <p>Observation, on 08/18/15 at 8:50 AM, revealed the ice machine had white streaks down the lid and the rubber seal in the upper right corner of the lid had a white and brown substance. The walk-in freezer contained a build up of chunks of ice under the freezer's ceiling fan and ice on the floor, back wall and along the side walls of the freezer. The conventional oven had a brown sticky substance across the stainless steel trim above the oven doors. The deep fryer had a dark brown to black hard crusted substance above the fryer basket holder. The vent hood over the stove top and fryer had substances ranging from yellow to gray to black on the removable vent plates. In addition, there were flecks of a yellow substance hanging down that could fall into food cooking on the range or fryer.</p> <p>Observations, on 08/19/15 at 9:55 AM, revealed there were no changes from the observations made on 08/18/15 of the freezer, stove, fryer, and toaster.</p> <p>Interview with the Dietary Director, on 08/20/15 at 2:50 PM, revealed she had a general cleaning schedule that was not specific to cleaning those areas. The Dietary Director stated she was unaware of how to clean the vent hood. The substance on the back of the fryer above the basket holder she stated was due to the daily frying the kitchen did and what was visible was just a two day build up. She was aware the facility had a outside contract to clean the vent hood every six (6) months, but the kitchen staff had not</p>	F 371	<p>hood vents and cooking equipment to assure cleanliness and operation (Attachment #12).</p> <p>4) The Food Service Director will provide an audit report to the QAPI Committee on a monthly basis for at least 12 months.</p> <p>Compliance Date: 9/20/2015 F371 - Additional detail: 9/15/2015</p> <p>On 8/20/15 and 8/21/15:</p> <ol style="list-style-type: none"> 1. The ice machine was emptied and terminally cleaned inside and out. 2. The toaster was thoroughly cleaned. 3. The deep fryer was emptied and cleaned. 4. The hood screens were terminally cleaned and replaced and the entire hood system was cleaned by the vendor. 5. The convection oven was cleaned. 6. The conventional oven was cleaned. 7. The service company was called to inspect the freezer coil and evaporator to determine the cause of the ice build-up. A plan to control ice build-up was put in place. 	8/21/2015
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 08/20/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203	
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F 371	Continued From page 16 cleaned the hood. She stated the toaster should not have a brown sticky substance on it. Review of the cleaning schedule for the kitchen revealed there were general assignments, deep cleaning was listed without specific instruction and the fryer was not listed for cleaning or grease changing. Interview with the Maintenance Director, on 08/19/15 at 3:20 PM, revealed a new motor had been placed in the freezer to prevent ice build up. The kitchen staff had tied back the vinyl curtains and he indicated he felt that was the cause of the ice build up in the freezer due to humidity each time the door was opened.	F 371	F371 Additional detail (cont.): When the terminal cleaning was completed on the items noted in the tag, the FSD completed a detailed review of the steamer, reach-in cooler, walk-in refrigerator, prep tables, steam table and food transport carts to insure that these areas were clean and in good repair. The administrator will receive a copy of the audit tool and personally inspect the kitchen on a weekly basis to insure the cleaning schedule is being adhered to.
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	1) Resident #11's ARNP removed the resident from isolation on 8/22/15. In addition, Resident #11's comprehensive care plan was reviewed to assure accuracy of current care needs. Resident #12, remained in isolation precautions as of 8/20/15. New signage indicating contact isolation precautions and the appropriate personal protective equipment (PPE) was placed onto the door of Resident #12's room on 8/20/15. Resident #12's care plan was updated on



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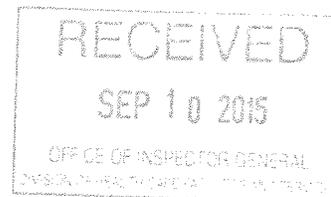
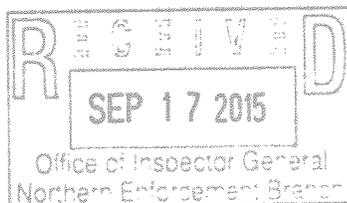
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203
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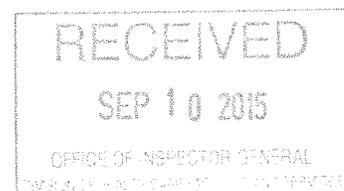
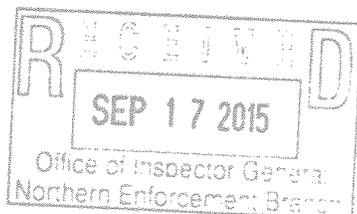
F 441	Continued From page 17 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. 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 staff consistently followed Isolation Precaution guidelines for Personal Protective Equipment (PPE) used for two (2) of three (3) residents in Contact Precautions (Residents #11 and #12. Staff was observed exiting the room of Resident #11 without removing PPE appropriately. Housekeeping was observed cleaning Resident #12's room without appropriate PPE. The findings include: Review of the facility's policy for Isolation Precautions, dated August 2005, revealed it was facility policy to prevent the transmission of	F 441	8/20/15 and 8/24/15 to reflect current isolation precautions (Attachment #1). 2) No other residents in the facility remained in isolation precautions. 3) The facility already has a comprehensive infection control program in accordance with Center for Disease Control (CDC) guidelines. It is the practice of the facility to incorporate isolation precautions into the plan of care when indicated. On 8/20/15, the nursing staff was re-educated by the Director of Nursing on the correct isolation precaution procedures (Attachment #2). In addition, the Staff Development Coordinator will educate all facility staff on infection control practices including updating a resident's plan of care and resident summary. Infection control practices training was already included in the	
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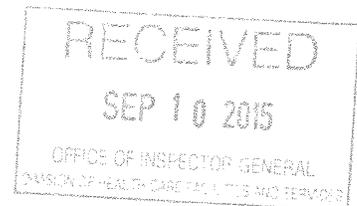
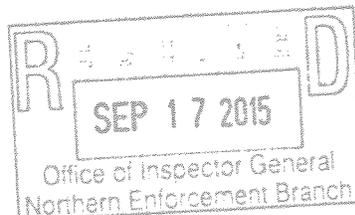
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F 441	<p>Continued From page 18</p> <p>infection through the use of isolation precautions. PPE should be used once and properly disposed in the trash before leaving the room. Standard Precautions were used for all residents at all times. Contact Precautions, plus standard precautions, were used for residents with known or suspected to have microorganisms that were easily transmitted by direct or indirect contact. Staff were to be informed of the initiation of isolation precautions as indicated. Appropriate precautions signage was to be posted on the resident's door. Other departments were to be notified of the precautions as appropriate. Hands were to be washed immediately after removing gloves to avoid transfer of microorganisms to other residents or environments. Gowns were to be worn if contact with secretions were likely.</p> <p>1. Review of the clinical record for Resident #11, revealed the resident was admitted by the facility, on 08/12/15, with diagnoses of Congestive Heart Failure with Exacerbation, Chronic Obstructive Pulmonary Disease, Diabetes, Cough, Shortness of Breath, Hypertension.</p> <p>Review of the clinical record for Resident #11, revealed the admission Minimum Data Set (MDS) assessment was not yet completed by the facility. The hospital Discharge Summary, dated 08/12/15 at 5:01 PM, revealed a chest x-ray was obtained, on an unknown date, which confirmed the resident had moderate left effusion and small right effusions from pulmonary edema.</p> <p>Review of the Care Plan, dated 08/13/15, for Resident #11, revealed the resident was at risk for respiratory complications; however, there was no documented evidence of the resident being on Contact Isolation.</p>	F 441	<p>facility's general orientation. This orientation has been expanded to include more information on different types of isolation precautions and their respective PPE usage (Attachment #3) as well as the updating of care plans. Moreover, new isolation precaution signage was implemented that better notify the staff of the type of isolation precaution and type of PPE that are required (Attachment #4). Lastly, a QAPI indicator has been added to the facility's existing QAPI program which already to include additional infection control monitoring. This indicator includes the Staff Development Coordinator auditing 100% of residents with isolation precautions for infection control compliance and verification of an updated plan of care and resident summary (Attachment #5). The Staff</p>	



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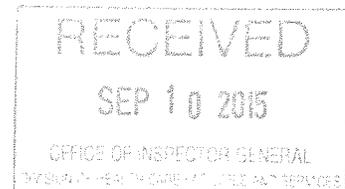
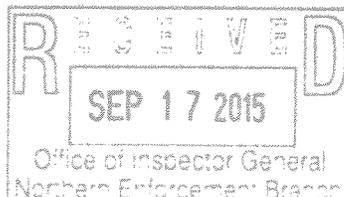
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F 441	<p>Continued From page 19</p> <p>Review of Resident #11's Summary Assessment, dated 08/13/15, revealed instructions for the CNAs on how to care for the resident. There was no documented evidence of instructions on contact precautions for nursing staff.</p> <p>Observation of Resident #11, during the initial facility tour, revealed a sign on the door instructing everyone to see the nurse before entering the room. There was a portable cabinet in the hall outside the room with masks, gowns, gloves and trash bags. There was no signage located for the type of precautions in place.</p> <p>Observation of Resident #11, on 08/19/15 at 12:28 PM, revealed a Physical Therapist leaving the resident's room wearing a mask and gloves. She walked down the hall while removing the PPE and discarded the items into the housekeeping cart located in the hall. She walked to the therapy room, entered the bathroom and washed her hands.</p> <p>Observation of Resident #11, on 08/19/15 at 12:38 PM, revealed a Speech Therapist exiting the resident's room while holding her hands together and up by her chest. She walked down the hall to an alcohol sanitizing dispenser where she sanitized her hands.</p> <p>Interview with the Director of Nursing during the initial facility tour, on 08/18/15 at 8:56 AM, revealed Resident #11 was a new admission on contact precautions related to a diagnosis of Methicillin Resistant Staphylococcus Aureous (MRSA) infection in the nose/sputum. She stated the resident was symptomatic in the hospital and cultures there revealed the MRSA.</p>	F 441	<p>Development Coordinator will provide an audit report monthly to the Director of Nursing.</p> <p>4) The Director of Nursing will provide an audit report to the OAPI Committee on a monthly basis for at least 12 months.</p> <p>Compliance Date: 9/20/2015</p> <p>F441 Additional detail: 9/15/15</p> <p>#1. The care plan for Resident #11 was reviewed by the DON on 8/22/2015. The care plan for Resident #12 was updated by the DON on 8/20/2015 and 8/24/15.</p> <p>#2. On 9/3/15, 9/8/15, and 9/16/15 all facility staff were inserviced on the proper use of PPE predicated upon the four (4) types of isolation situations that may be required. All staff completed as post-test to verify their knowledge of the proper PPE to use in those situations.</p> <p>#3. The SDC will be using the audit tool, identified as Attachment #5, to audit and verify staff compliance with isolation precautions and use of proper PPE through concurrent review and observaton. The actual audits will be performed by SDC, Unit Manager, and charge nurses on all shifts.</p>



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F 441	Continued From page 20 Interview with the Physical Therapist, on 08/19/15 at 12:28 PM, revealed she discussed with a nurse regarding the PPE required whenever a resident was in isolation precautions. She stated she was trained by her corporation on isolation/transmission-based precautions. She stated she was not aware that gloves and masks were to be removed prior to exiting the resident's contact precaution room or that hands were to be washed prior to exiting the room or that microorganisms could be spread to other residents and/or environments. Interview with the Speech Therapist, on 08/19/15 at 12:40 PM, revealed she had not been trained to wash her hands after removing PPE in the resident's room and prior to leaving the room. She stated she was new and was not aware of the facility's policies. She stated bacteria could be spread to others by not washing hands prior to leaving the isolation room. 2. Review of the clinical record for Resident #12, revealed the facility admitted the resident on 05/21/15 with diagnoses to include Dementia with Behavioral Disturbance, Psychosis, Atrial Fibrillation, Gout, Hypertension, Cataracts, Dysphagia and Renal Failure. Review of the Minimum Data Set assessments, dated 06/25/15, revealed Resident #12's Brief Interview for Mental Status (BIMS) was a 10/15 and the resident required extensive assistance with all activities of daily living. The resident was incontinent of bowel and bladder. Review of the comprehensive care plan, dated 08/14/2015, revealed the resident had an active	F 441	



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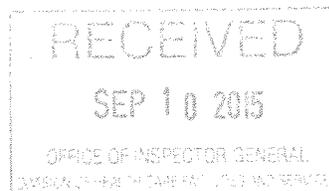
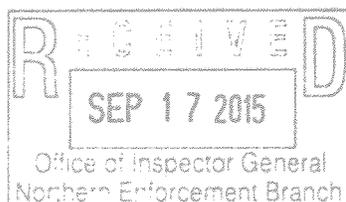
F 441 Continued From page 21
shingles infection with open skin and was placed in contact precautions.

F 441

Observation of Resident #12 during the initial facility tour, on 08/18/15 at 8:56 AM, revealed a sign on the door of the resident's room instructing visitors to see a nurse before entering the room. There was no evidence of a sign identifying the type of precautions in place. There was a small cart sitting in the hall outside the resident's door containing gloves, masks, gowns and trash bags.

Observation of Resident #12, on 08/18/15 at 11:09 AM, revealed the door to the resident's room was open and a housekeeper, wearing gloves, had a cleaning cloth and was wiping down the bed and other furniture in the room. Her clothing was noted to be in contact with the resident's bed, linens, and bedrails. She then emptied the resident's trash into the bag on the housekeeping cart sitting in the hall outside the resident's room and gave the floor a final wipe with a mop. The mop was then taken from the room and returned to the mop bucket on the housekeeping cart.

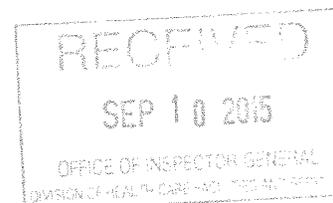
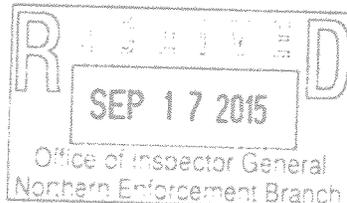
Interview with the Housekeeper, on 08/18/15 at 11:25 AM, revealed she was trained to clean isolation rooms and she always asked nursing regarding the appropriate PPE to wear in the room. She stated there were no written instructions provided to assist in determining the PPE to wear. She stated the nurse, could not remember her name, told her she did not need anything but gloves to enter the contact precaution room of Resident #12. She stated she wiped down the furniture, swept and mopped the floor and emptied the trash into the housekeeping cart bag located in the hall outside the room.



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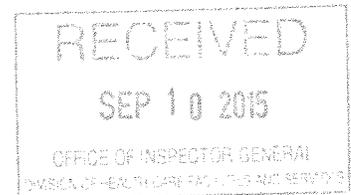
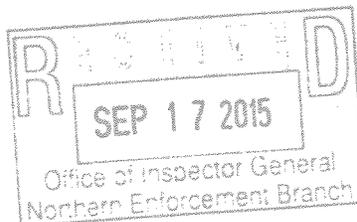
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F 441	Continued From page 22 Interview with LPN #7, on 08/18/15 at 3:41 PM, revealed there were no care plan instructions for Resident #11. She stated that was why the sign on the door instructed staff to ask a nurse for advice on the PPE required when providing care to the resident. She stated she had received training from the facility some time ago; however, she was not sure if a gown should be worn when providing care for Resident #11 with MRSA in the nose/sputum. She stated bacteria could spread to other residents from clothing. Interview with Certified Nurse Aide (CNA) #1, on 08/20/15 at 12:51 PM, revealed you should always wear a gown and gloves when you go into isolation. She stated she removed her gloves then untied the gown and removed it carefully and place in trash container in the room. She stated there were no instructions in the computer for how to do contact precautions and what PPE to wear for Resident #12. She indicated germs could be passed to other residents making them sick. Interview with Licensed Practical Nurse (LPN) #4, on 08/20/15 at 1:20 PM, revealed she supervised the nursing aides on the unit. She stated she was not able to locate the resident summary assessment for Resident #11 and did not know if there were instructions for the contact precautions. Interview with the Director of Nursing, on 08/20/15 at 3:06 PM, revealed gowns were to be worn when entering a contact precaution room. She stated the resident summary assessment for Residents #11 and #12 should include	F 441		



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F 441	Continued From page 23 instructions for each resident's care, including contact isolation.	F 441	



**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER K1 185468	FACILITY NAME CHRISTIAN HEALTH CENTER - WEST, INC	SURVEY DATE *K4 08/20/2015
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K6 DATE OF PLAN APPROVAL 01/01/1982	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING <u>01</u>	<input checked="" type="checkbox"/> A A BUILDING B WING C FLOOR D APARTMENT UNIT
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LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

***K7** 12 SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: 1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: 4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: 7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: e.g 2.5

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: 3 **K56:** 3

***K9 : FACILITY MEETS LSC BASED ON: (Check all that apply)**

A1 <input type="checkbox"/>	A2 <input checked="" type="checkbox"/>	A3 <input type="checkbox"/>	A4 <input type="checkbox"/>	A5 <input type="checkbox"/>
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: A. <input checked="" type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> FULLY SPRINKLERED PARTIALLY SPRINKLERED NONE (All required areas are sprinklered) (Not all required areas are sprinklered) (No sprinkler system)
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***MANDATORY**

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

PRINTED: 09/22/2015
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 01 - CHRISTIAN HEALTH CENTER - WEST B. WING _____	(X3) DATE SURVEY COMPLETED R 09/21/2015
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/21/15 as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185468	(Y2) Multiple Construction A. Building B. Wing 01 - CHRISTIAN HEALTH CENTER - WEST	(Y3) Date of Revisit 9/21/2015
Name of Facility CHRISTIAN HEALTH CENTER - WEST, INC		Street Address, City, State, Zip Code 1015 MAGAZINE STREET LOUISVILLE, KY 40203

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0029	Correction Completed 09/20/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0046	Correction Completed 09/20/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 09/21/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <i>my</i>	Reviewed By <i>lx</i>	Date: 09/22/15	Signature of Surveyor: <i>Michele Zornstein</i>	Date: 9/22/15
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/20/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2015
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - CHRISTIAN HEALTH CENTER - WEST B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203		
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1982 REMODELED: 2011 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story and a partial basement, Type V Protected. SMOKE COMPARTMENTS: Seven (7) smoke compartments. FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system. GENERATOR: Type II 45KW generator. Fuel source is diesel. A Recertification Life Safety Code Survey utilizing the 2786S Short Form, was conducted on 08/20/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility is certified for ninety-two (92) beds with a census of eighty-four (84) on the day of the survey.	K 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and 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 this statement of deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.		

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

TITLE

(X6) DATE

Administrator

9/9/2015

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.

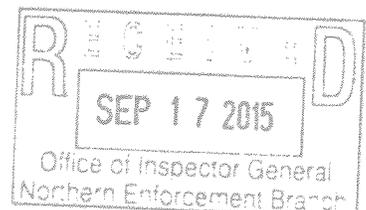
SEP 17 2015
Office of Inspector General
Northern Enforcement Branch

SEP 10 2015
OFFICE OF INSPECTOR GENERAL
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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

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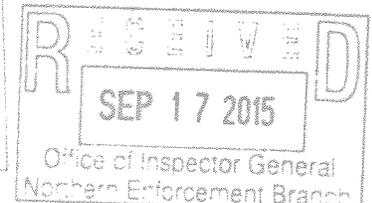
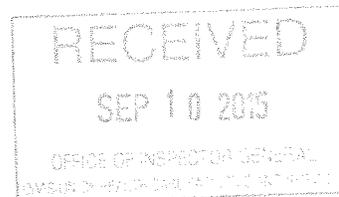
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K 029	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observation, on 08/20/15 at 9:53 AM, with the Administrator and the Maintenance Manager revealed a bulk food storage cart was being used to hold open the self-closing door to the Dry Storage Room located in the Kitchen, preventing the door from closing as required.</p> <p>Interview, on 08/20/15 at 9:54 AM, with the Administrator revealed he was aware of the requirements for doors to hazardous storage rooms; however, he was not aware the door was being held open.</p> <p>The census of eighty-four (84) was verified by the Administrator on 08/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Manager at the exit interview on 08/20/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the</p>	K 029	<p>3) A QAPI indicator was established to have the Maintenance Director complete a monthly audit of all self-closing doors in the kitchen to assure no self-closing doors are improperly held open (Attachment #13).</p> <p>4) The Maintenance Director will provide an audit report to the QAPI Committee on a monthly basis for at least 12 months.</p> <p>Compliance Date: 9/20/2015</p>



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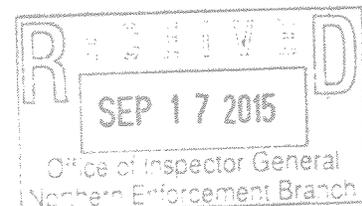
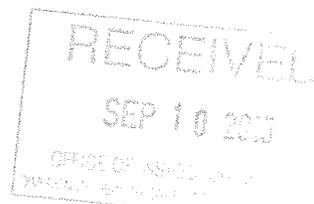
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K 029	<p>Continued From page 3</p> <p>following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:</p> <ol style="list-style-type: none"> (1) Upon release of the hold-open mechanism, 	K 029	



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K 029	Continued From page 4 the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility has the capacity for ninety-two (92) beds and the census was eighty-four (84) on the day of the survey. The findings include:	K 046	1) The battery-powered, emergency lighting in the boiler room noted in the survey report was tested for 30 seconds on 8/22/15 and for 90 minutes on 9/8/15 by the Maintenance Director. These tests were properly documented. 2) The battery-powered emergency light noted in the survey report is the only light of this type within the facility. 3) The Maintenance Director was educated on NFPA 101 (2000 edition) 7.9.2.1 by



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K 046	<p>Continued From page 5</p> <p>Record Review, on 08/20/15 at 11:00 AM, with the Maintenance Manager revealed the facility failed to document the monthly thirty (30) second test and the annual ninety (90) minute test for battery powered emergency lighting.</p> <p>Interview, on 08/20/15 at 11:01 AM, with the Maintenance Manager revealed he was not aware that documentation was to be provided for the thirty (30) second monthly and ninety (90) minute test for battery powered emergency lighting.</p> <p>The census of eighty-four (84) was verified by the Administrator on 08/20/15. The survey findings were acknowledged by the Administrator and verified by the Maintenance Manager at the exit interview on 08/20/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted</p>	K 046	<p>the Director of Housing on 9/8/15 (Attachment #14). In addition, a QAPI indicator was established for the Maintenance Director to complete a documented 30-second test monthly and a 90-minute test on this light (Attachment #15). The Maintenance Director will provide a completion report to the Administrator monthly.</p> <p>4) The Administrator will provide an audit report to the QAPI Committee on a monthly basis for at least 12 months.</p> <p>Compliance Date: 9/20/2015</p>

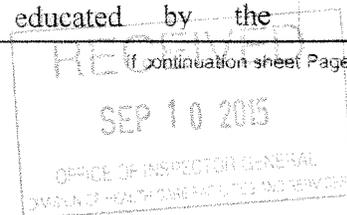
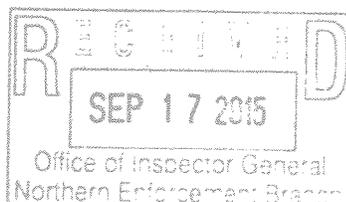
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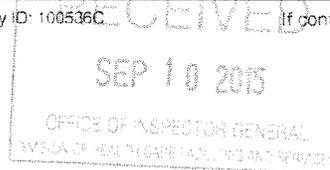
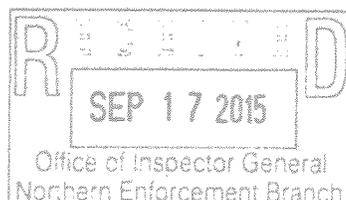
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135468	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - CHRISTIAN HEALTH CENTER - WEST B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2015
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K 046	Continued From page 6 on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on an interview and record review, it was determined the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency	K 144	1) The timer switch on the generator was repaired on 8/31/15 by Wayne Supply, our generator service contractor. The light on the generator annunciator panel will be repaired by our generator contractor by 9/20/15. The weekly and monthly generator checks did resume as of 7/20/15. 2) The facility has only one generator and generator annunciation panel. 3) The Maintenance Director was educated by the	



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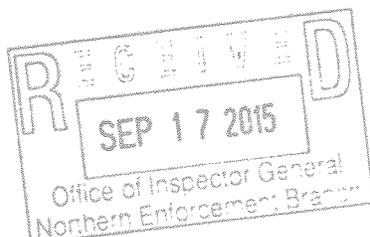
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K 144	<p>Continued From page 7</p> <p>had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility has the capacity for ninety-two (92) beds with a census of eighty-four (84) on the day of the survey.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the Generator documentation, on 08/20/15 at 10:54 AM, with the Maintenance Manager revealed the facility did not have weekly documentation for the generator from 06/23/15 until 07/20/15. <p>Interview, on 08/20/15 at 10:55 AM, with the Maintenance Manager revealed a timer had stopped working and when it was reset it ran the generator at a time when he was not present to monitor and document the test.</p> <ol style="list-style-type: none"> Observation, on 08/20/15 at 11:19 AM, with the Maintenance Manager revealed the light indicating low battery voltage was not functioning on the generator annunciator panel. <p>Interview, on 08/20/15 at 11:20 AM, with the Maintenance Manager revealed he was not aware the light was not functioning.</p> <p>The census of eighty-four (84) was verified by the Administrator on 08/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Manager at the exit interview on 08/20/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 110 (1999 Edition).</p>	K 144	<p>Director of Housing on 9/8/15 on NFPA 110 related to the proper testing and documentation of emergency power supply sources (Attachment #14). In addition, a QAPI indicator was established for the Maintenance Director to assure the weekly and monthly generator checks are properly completed and documented (Attachment #16). This indicator will be provided to the Administrator monthly for review.</p> <ol style="list-style-type: none"> The Administrator will provide an audit report to the QAPI Committee on a monthly basis for at least 12 months. <p>9/21/2015 Compliance Date: 9/20/2015</p> <p>K144: Additional detail-</p> <p>The light on the annunciator panel was replaced on 9/8/2015, in the interim, the Maintenance Director was tasked with performing manual low voltage checks by direct observation and recording same.</p>



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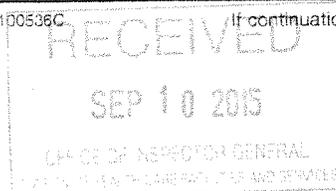
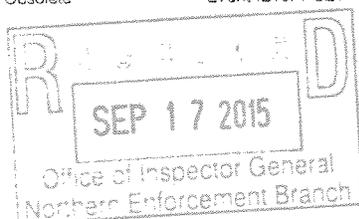
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135468	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - CHRISTIAN HEALTH CENTER - WEST B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC		STREET 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)
K 144	<p>Continued From page 8</p> <p>Reference: NFPA 99 (1999 Edition) 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.)</p> <p>The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]</p> <p>Reference: NFPA 110 (1999 Edition) 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency</p>	K 144	



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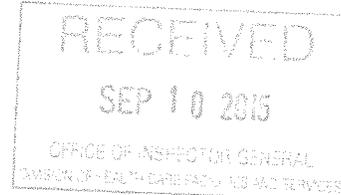
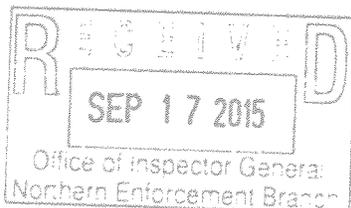
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - CHRISTIAN HEALTH CENTER - WEST B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2015
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K 144	Continued From page 9 lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Reference: NFPA 99 (1999 Edition) 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in	K 144		



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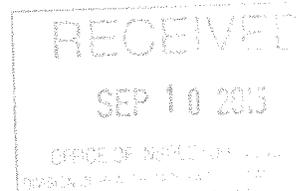
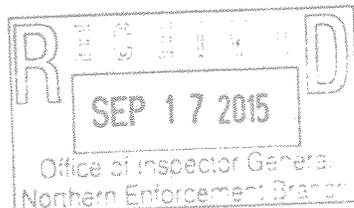
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K 144	<p>Continued From page 10</p> <p>accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>Reference: NFPA 99 (1999 Edition) 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>Reference: NFPA 99 (1999 Edition) 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be</p>	K 144	



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K 144	<p>Continued From page 11 established</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted.</p> <p>Reference: NFPA 110 (1999 ed.) 5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter, uninsulated or insulated exhaust pipes, and other heat-producing equipment. 5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related accessory equipment that exceed the recommendations of the manufacturer. 5-7.3 For the EPS equipment room, the ventilation or cooling</p>	K 144		



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K 144	Continued From page 12 equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer ' s criteria or allowable maximum temperatures.	K 144		

