

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

PRINTED: 07/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2011
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220
-------------------------------------------------------------------------	-----------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 000	INITIAL COMMENTS An abbreviated standard survey was conducted 06/27/11 through 06/29/11, investigating KY00016586 and KY00016631. KY00016586 was unsubstantiated with no regulatory violation. KY00016631 was substantiated with regulatory violations and deficiencies cited.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.	
F 151	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS SS=D - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of the facility's policy it was determined the facility failed to one (1) of three (3) sampled residents exercised his/her right as a resident of the facility and as a citizen of the United States. Resident #1 was not afforded the right to smoke by the facility after the resident's request was made known to the facility. The findings include: Record review of the facility's policy Safe Smoking (undated) revealed the facility's interdisciplinary team members (IDT) determined if a resident was a safe smoker or dependent smoker before the resident exercised the privilege to smoke. Further review of the Safe Smoking policy revealed dependent smokers are	F 151	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F151 It is the practice of this facility to allow residents the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination and reprisal from the facility in exercising his or her rights.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X5) DATE 7/18/11
---------------------------------------------------------------------------------------------	-----------------------------	----------------------

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: XUQ11 Facility ID: 100201

If continuation sheet Page 1 of 6

RECEIVED

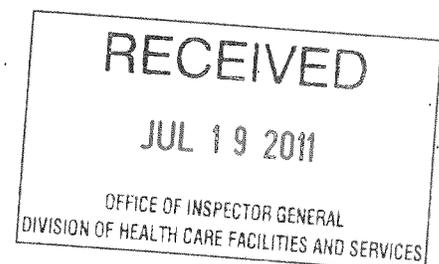
JUL 19 2011

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 07/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2011
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151	<p>Continued From page 1 not left unsupervised while smoking.</p> <p>Observation of Resident #2, on 06/28/11 at 8:10AM, 10:00AM, 11:15AM and 2:00AM revealed the resident outside in a designated smoking area. Resident #2 was wearing a protective apron while smoking and no supervision present.</p> <p>Observation of Resident #3, on 06/28/11 at 8:40PM, 12:20PM, 1:35PM and 3:45PM, revealed the resident outside in a designated smoking area. Resident #3 was wearing a protective apron and no supervision present.</p> <p>Observation of Resident # 1, on 06/28/11 at 8:00AM, 8:45AM, 9:00AM, and 11:00AM revealed the resident was up in a wheelchair in room watching TV. Further observation at 3:45PM revealed a family member transferred Resident #1 by wheelchair to the smoking area. The family member provided Resident #1 with a cigarette and lighter. Observation of the smoking area revealed Resident #1 socializing with Resident #2 and #3 (both whom are smokers) and a unidentified non-smoking resident. Continued observation of the smoking area at 4:00PM revealed a family member transported Resident #1 via wheelchair back into her/his room.</p> <p>Interview via phone with Resident #1's family member, on 06/27/11 at 5:30PM, revealed Resident #1 would not be allow to smoke unless family or friends where available to supervise.</p> <p>Interview with Resident #1, on 06/28/11 at 11:10AM revealed she/he enjoys smoking and would like to smoke.</p>	F 151	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Residents #1, #2 and #3 have been provided opportunity to smoke and supervision is provided during their smoking periods.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice –Residents expressing a desire to smoke have the potential to be effected by this deficient practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur – The facility QAA committee with review and adopt</p>	

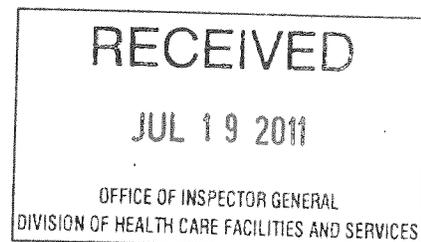


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2011
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151	Continued From page 2 Interview with LPN #1, on 06/28/11 at 2:50PM, revealed residents are evaluated to determine if they are independent or dependent with smoking. If a resident is a dependent smoker, they have the right to smoke, but staff will not supervise. Interview with LPN #2, on 06/28/11 at 3:00PM revealed residents identified as a dependent smoker have the right to smoke only when supervised by someone other than staff. Interview with Unit Manager (200), at 3:20pm, revealed dependent resident smokers have the right to smoke, however, only if a family member or friends are available. Interview with the Administrator, at 3:45PM, revealed residents are evaluated for independent or dependent smoking. Dependent smokers have the right to smoke if family are available to supervise or if staff is willing to supervise. Review of Resident #1's medical record revealed the facility readmitted the resident on 01/02/11, with diagnoses of Congestive Heart Failure, Weakness and Chronic Obstructive Airway. The MDS dated 04/15/11 revealed a Brief Interview for Mental Status (BIMS) score 13. Further review of the record revealed the Safe Smoking evaluation dated 04/05/11 revealed the resident had physical limitations of unable to open door independently and exhibited adequate memory, vision and motor skills. The Safe Smoker Evaluation dated 04/25/11 and 05/25/11 revealed a dependent smoker required staff, family, friend or physical support to supervise smoking.	F 151	the amended smoking policy. The facility further will educate the IDT members and center staff on the facility smoking guidelines and smoking evaluation tool and annually thereafter. A resident council meeting will be held with residents desiring to attend during which the new smoking guidelines will be presented. Each smoking resident will be personally invited to attend the meeting by the secretary of the Council and informed of meeting agenda. Written communication will be provided to families advising them of the facility smoking guidelines. Supervision will be provided to residents desiring to smoke by a member of the facility staff. How does the facility plan to monitor its performance to ensure that solutions are sustained - The facility Activities Director will monitor supervision compliance through the use of the monitor signature sheet. Findings will be presented to the facility QAA committee monthly.	
F 323	483.25(h) FREE OF ACCIDENT	F 323		

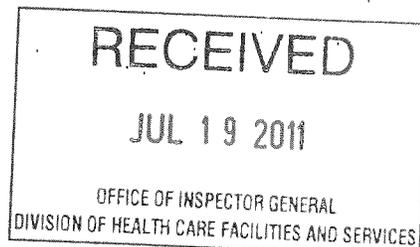
*Compliance date: 7-16-11 PB
Per Jane Gibb-Williams*



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

PRINTED: 07/12/2011
FORM APPROVED
OMB NO. 0938-0391

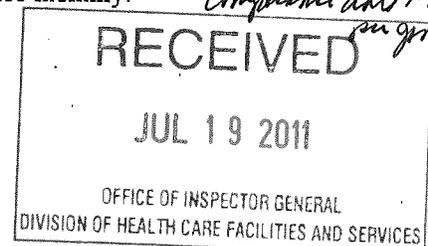
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2011
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 323 SS=D	<p>Continued From page 3</p> <p>HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure an environment that was free from accident hazards and provide supervision to each resident to prevent avoidable accidents for one (1) of three (3) sampled residents (#1).</p> <p>The findings include:</p> <p>Record review of the facility's policy Safe Smoking (undated) revealed the facility's interdisciplinary team members (IDT) determine if a resident was a safe smoker or a dependent smoker before the resident exercised the privilege to smoke. Further review of the Safe Smoking policy revealed dependent smokers are not left unsupervised while smoking.</p> <p>Observation of Resident #2, on 08/28/11 at 8:10AM, 10:00AM, 11:15AM and 2:00PM, revealed the resident was outside smoking in the designated smoking area. Resident #2 wore a protective apron while smoking however, no supervision was present.</p>	F 323	<p>F323</p> <p>It continues to be the practice of the facility to ensure that the resident environment remains as free of accident hazards as is possible' and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice - Residents #1, #2 and #3 have been provided opportunity to smoke and supervision is provided during their smoking periods.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice? - Residents expressing a desire to smoke have the potential to be effected by this deficient practice.</p>



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

PRINTED: 07/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2011
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 Observation of Resident #3, on 06/28/11 at 8:40AM, 12:20PM, 1:35PM and 3:45PM revealed the resident was outside smoking in the designated smoking area. Resident #3 was wearing a protective apron however, no supervision was present at this time. Observation of Resident # 1, on 06/28/11 at 8:00AM, 8:45AM, 9:00AM, and 11:00AM revealed the resident up in a wheelchair in their room watching TV. At 3:45PM a family member transferred Resident #1 by wheelchair to the smoking area. The family member provided Resident #1 with a cigarette and a lighter. Observation of the smoking area revealed Resident #1 socializing with Resident #2 and #3 (both whom are independent smokers). Observation of the smoking area at 4:00PM revealed a family member transported Resident #1 via wheelchair back into her/his room. Interview with Resident #1, on 06/28/11 at 11:10AM revealed she/he enjoyed smoking and would like to smoke however, no staff will supervise while smoking. Interview with LPN #1, on 06/28/11 at 2:50PM revealed residents are evaluated to determine if they are independent or a dependent smoker. She further revealed if a resident is a dependent smoker, they may only smoke when family or friends are available to assist. Interview with LPN #2, on 06/28/11 at 3:00PM, revealed residents who are identified as a dependent smoker must have family or a friend to supervise smoking because staff will not provide	F 323	What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur – A smoking evaluation will continue to be completed by a licensed nurse when the resident expresses a desire to smoke. Results will be presented to the facility Interdisciplinary Care Team (IDT) for development of a comprehensive patient care plan. The resident will be provided protective equipment, should the evaluation indicate. Retention, storage and distribution of smoking accessories will be kept under the control of the facility staff when not in use. The center will establish designated times and locations for resident smoking. Safety equipment, to include a fire blanket and extinguisher, will be accessibly located near the designated smoking locations. How does the facility plan to monitor its performance to ensure that solutions are sustained – The assigned monitor for each smoking period will evaluate and ensure that smoking residents comply with specifications identified in their individualized plan of care. Any variances from plan will be reported immediately to the licensed charge nurse and the facility safety committee. The facility Safety Committee Chairperson will report any adverse findings to the facility QAA Committee monthly.	



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

PRINTED: 07/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2011
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 the supervision. Interview with the Unit Manager (200), at 3:20PM, revealed residents must have family or friends available to take them to smoke. Dependent smoking residents would not be supervised by staff. Interview with the Administrator, at 3:45PM, revealed residents are evaluated for independent or dependent smoking. If a resident is assessed as a dependent smoker the family or friends would be responsible to supervise the resident's smoking. She further revealed staff would have to be willing to supervise resident while smoking. Review of Resident #1's medical record revealed the facility readmitted the resident on 01/02/11 with diagnoses of Congestive Heart Failure, Weakness and Chronic Obstructive Airway. The MDS dated 04/15/11 revealed a Brief Interview for Mental Status (BIMS) score 13. Further review of the record revealed the Safe Smoking evaluation on 04/05/11 indicated the resident had physical limitations of unable to open the door independently and exhibited adequate memory, vision and motor skills. Review of the Safe Smoking evaluation dated 06/25/11 revealed the resident had physical limitations that interfered with their ability to perform safe smoking techniques. Further review of the Safe Smoker Evaluation dated 04/25/11 and 05/25/11 revealed a dependent smoker required staff, family, friend or physical support to supervise smoking.	F 323		

