

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

PRINTED: 12/18/2016  
FORM APPROVED  
OMS NO 0930-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: In Care Enforcement Branch B. WING	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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	F 000	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Lancaster of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Lancaster files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	
F 242 SS-E	483.15(b) SELF-DETERMINATION- RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to afford the right to choose schedules, consistent with his or her interests, assessments, and plans of care and make choices about aspects of his or her life in the facility that are significant for two (2) of eighteen (18) sampled residents (Resident #4 and Resident #13) and one (1) unsampled resident (Resident A). Resident #4, Resident #13, and Resident A were not afforded the opportunity to choose when they got up in the morning or where they spent the morning.  The findings include:  Review of the facility's policy titled "Resident Rights," dated 02/09, revealed the facility must promote care for residents in a manner and in an environment that promotes maintenance or	F 242	<u>Corrective Actions for Targeted Residents</u>  Residents #4 and #13 and Resident A were interviewed by the Administrative Staff on 12/8/15 to inquire of Residents' preferences of daily getting up time as well as where they prefer to spend the morning. Results of these interviews were communicated to the Director of Nursing for front-line staff assignments to include residents' wake up/get up times, per the residents' preferences, and where the residents would like to spend the morning. Results from these interviews will be documented on the Nurse's Aide Care Plan (Kardex) to ensure residents' choices are honored.  Continued	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE

TITLE

*[Signature]*

*Executive Director*

1/8/2016

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  BJVHIG	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 242	<p>Continued</p> <p>enhancement of each resident's quality of life and self-determination and participation. The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care.</p> <p>Observation on 12/02/15 at 6:00AM revealed twelve (12) residents were observed in the Main Dining Room including Resident #4, Resident #13, and Resident A. Resident #4 was sitting at a table in a wheelchair facing a wall. Resident #13 was sitting in a wheelchair at another table across the room facing a wall slumped over with his/her head bobbing up and down and with his/her eyes closed. Resident A was at the same table beside Resident #13 with his/her eyes closed.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident on 07/08/15 with diagnoses of Bacteremia, Lower UTI, Dehydration, Acute Kidney Injury, Fever, Sepsis, and Alzheimer's Dementia. Review of the Initial Minimum Data Set (MDS) assessment dated 07/15/15, revealed the resident's daily decision-making capabilities were intact which indicated Resident #4 was interviewable. The facility has assessed Resident #4's daily preferences as bedtime being somewhat important. Resident #4's activity preferences were as follows: doing things with groups of people, going outside, music, news, reading, animals, and participating in religious services or practices.</p> <p>Interview with Resident #4 on 12/02/15 at 10:25 AM revealed the SRNAs get the resident up around 5:00AM every morning. The resident said sometimes he/she doesn't want to get up that early but he/she felt like he/she had to</p>	F242	<p>1:1 and group education for Nursing Staff on duty was initiated on 12/3/15 by the Executive Director regarding the importance of honoring residents' choices of aspects of his or her life that are significant to the resident, to include the residents' preferences for wake up/get up times and where residents would prefer to spend the morning.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current residents have the potential to be affected by this practice. Interviews were conducted with facility Residents/Responsible Party by Administrative Staff beginning 12/8/15 to inquire of residents' preferences of daily get up time as well as where the residents would like to spend the morning. These interviews will be completed by 12/24/15 by Administrative Staff. Results of these interviews will be communicated to the Director of Nursing for front-line staff assignments to include residents' wake up/get up times, as well as where the residents would like to spend the morning. Results from these interviews will also be documented on the Nurse's Aide Care Plan (Kardex). A list of these preferences will be maintained and updated as needed by the DON.</p> <p><u>Systematic Changes</u></p> <p>During the Admission Process, the Social Service Director will interview the resident regarding choices significant to the resident, to include time of getting up daily and where the resident prefers to spend the morning.</p> <p style="text-align: right;">Continued</p>

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(K4) 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)	(K5) COMPLETION DATE
F 242	<p>Continued</p> <p>because staff kept asking.</p> <p>Review of Resident #13's medical record revealed the facility admitted the resident on 00/31/06 with diagnoses of "Acute Kidney Injury Prerenal, Concern of Renal Vascular Insuff, UTI, HTN, Osteoarthritis, COPD, GERD, CKD Stage IV, Breast CA in the past, peripheral neuropathy, advancing Dementia, anemia SEC to CHR Kidney DZ, slp mastectomy." Review of the annual Minimum Data Set (MDS) assessment dated 02/12/15, revealed the resident's daily decision-making capabilities were intact which indicated Resident #13 was interviewable. The facility assessed Resident #13's daily preferences as choosing own bedtime as being somewhat important. Resident #13's activity preferences were as follows: going outside, music, news, reading, and animals.</p> <p>Interview with Resident #13 on 12/02/15 at 6:16 AM revealed staff gets him/her up every morning at 5:00AM. Resident #13 said that he/she has told staff in the past that he/she did not want to get up but staff got him/her up anyway. The resident said that he/she had told staff this morning he/she did not want to get up because of having pneumonia and feeling really bad but they got him/her up anyway.</p> <p>Review of Resident A's Brief Interview for Mental Status (BIMS) assessment revealed the resident scored a 13 which meant the resident was cognitively intact and could be interviewed.</p> <p>Interview with Resident A on 12/02/15 at 6:25 AM revealed he/she did not want to get up early this morning and had told the staff but staff must have thought "I was just playing. I got up anyway."</p>	F 242	<p>During the Quarterly MDS Assessment and/or Quarterly Care Plan Meetings, the Resident/Responsible Party will be asked by the Interdisciplinary Team if there are any changes in the resident's choices about aspects of his/her life that are significant to them, to include the time to get up daily and where the resident prefers to spend the morning. The Director of Nursing will update preference results from these meetings for communication to the front-line staff to reflect residents' preferences significant to them.</p> <p>A Mandatory Staff Meeting was held by the Executive Director for Facility Staff on 12/10/15 regarding the importance of honoring residents' choices of aspects of his or her life that are significant to the resident, to include the residents' preferences for daily wake up time and where the residents prefer to spend the morning. This in-service will be repeated by the Executive Director on 1/14/16 to ensure Facility Staff is educated. Newly-hired Facility Staff will be educated by the Social Services Director during their orientation period regarding the importance of honoring residents' choices of aspects of his or her life that are significant to the resident, to include the residents' preferences for daily wake up times and where the resident prefers to spend the morning.</p> <p><u>Monitoring</u></p> <p>A monthly audit will be conducted by the Director of Nursing by interviewing residents as to their choices of aspects of his or her life that are significant to the resident, to include the residents' preferences for wake up/get up times and where residents would prefer to spend the morning. The residents' preferences will be compared to the information the facility already has for the residents' preferences to ensure resident choices are honored.</p> <p>Continued</p>	

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(X4) ID PREFIX TAG  F 242	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG  F242	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE  1/15/16
	<p>Continued</p> <p>According to Resident A, staff routinely get residents up early and takes them to the dining room where most of the residents slept.</p> <p>Interview with Certified Medication Aide (CMA) #2 on 12/03/15 revealed she knows the Nurse Aides get residents up around 5:00AM. According to CMA #2, she did not know why they (Nurse Aides) got residents up that early. The CMA stated the Nurse Aides usually take the residents to the dining room and she (CMA#2) worried that a resident was going to fall out of a chair and staff would not be around to see them. CMA #2 said she had seen residents in the dining room fall forward because they are so sleepy. The CMA said she thought it was mostly for convenience because the Nurse Aides are so busy in the mornings getting everyone ready for breakfast.</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 12/03/15 at 3:08 PM revealed sometimes she would start her shift at 3:00AM. SRNA #3 stated she would get residents up around 6:00AM and take most of them to the Dining Room. SRNA #3 said sometimes the residents do not want to go and she encouraged them to go. The facility has a list of who the SRNAs are to get up every morning. The SRNA said a lot of times residents fall asleep in the dining room but night shift nurses get mad if you do not get them up. According to the SRNA, she felt like Licensed Practical Nurse (LPN) #2 really pushed the SRNAs to get residents up early. The SRNA said if the Nurse Aides did not get the residents up, the LPN gets "ticked" and the SRNAs fear they would be in trouble; SRNA #3 works a split shift sometimes.</p> <p>Interview with State Registered Nurse Aide #4 on</p>		<p>The results of this audit will be presented by the DON to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then quarterly. The QAPI Committee consists of The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
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F 242	<p>Continued</p> <p>12103115 at 5:29 PM revealed she works night shift and usually starts assisting residents to get up around 5:00AM. The facility has a list of residents who staff assists up and some residents will sit in the dining room for two to three hours before breakfast is served around 8:00AM. SRNA #4 said she had seen residents fall asleep in the dining room. According to SRNA #4, the Director of Nursing compiled the list of residents who the SRNAs are to assist up early in the AM.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 12/03/15 at 5:29 PM revealed SRNAs start getting residents up around 5:00AM and some residents wanted to get up earlier. LPN #2 said the office generated a list of residents staff was to get up. According to LPN #2, staff encouraged residents to get up but did not force them to get up. The LPN said most of the residents "get used to it." The LPN said she did not think it was appropriate for a resident to sit in the dining room from 5:00AM till 8:00AM before receiving a tray. LPN #2 said she understood that is a long time to sit there and "most of them don't have their right mind."</p> <p>Interview with the Director of Nursing (DON) on 12/03/15 at 7:24 PM revealed night staff usually gets some of the residents up at 5:00AM as some of the residents go to bed really early and want to get up early. The DON said she did not know where "the list" of residents to get up early came from but nurses are to assess residents upon admission for their preferred wake-up times/get-up times. The DON said SRNAs should not get residents up if they do not want to get up. According to the DON, she was not aware that staff was getting residents up when they did not want to get up.</p>	F242			

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(X4) TO 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 248 SS=E	<p>483.15(1) (1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to provide an ongoing program of activities designed to meet the physical, mental, and psychosocial well-being of three (3) of eighteen (18) sampled residents (Resident #4, Resident #13, and Resident #16). The facility failed to consider Resident #4 and Resident #13's poor vision when planning and providing activities. The facility failed to provide activities for Resident #15 with provisions made for the resident's hearing loss.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Activities," which contained a revision date of December 2013, revealed individual activities would be provided for residents because all residents have a need for personal identity, and because some were unable to participate in group activity. However, the policy did not address developing activities for residents with hearing or vision impairment.</p> <p>1. Review of Resident #4's medical record revealed the facility admitted the resident on</p>	F248	<p><u>Corrective Actions for Targeted Residents</u></p> <p>Residents #4 and #13 were added to the 1:1 Activities Program on 12/3/15 by the Activities Director. Resident #4 and Resident #13 will receive an Activities Program with 1:1 activities three times a week to meet his/her individual needs of being visually impaired. A noise amplifying device was ordered for Resident #15 on 12/4/15 by the Activities Director. Resident #15 is being encouraged to participate in Activities by the Activities Staff and is seated near the activity to assist the resident in hearing when the resident does participate.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current residents have the potential to be affected by this practice. Beginning 12/7/15, facility residents' initial comprehensive assessments are being reviewed by the Activity Staff to ensure the current Activity Program for each resident matches these assessments. This review will focus on providing an Activities Program for residents with vision or hearing loss. The Activities Director was counseled on 12/9/15 by the Executive Director regarding the need for providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident, with focus on the hearing and vision impaired.</p> <p><u>Systematic Changes</u></p> <p>During the Quarterly MDS Assessment and/or the Quarterly Care Plan Meetings, the Resident/Responsible Party will be asked by the Interdisciplinary Team if there are any changes in the resident's activity preferences, to include 1:1 activities or special activity needs such as for hearing and vision impaired residents.</p> <p>Continued</p>		

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WEST MAPLE AVENUE LANCASTER, KY 40444		
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F 248	<p>Continued</p> <p>07/08/15 with diagnoses of Bacteremia, Lower Urinary Tract Infection, Dehydration, Acute Kidney injury, Fever, Septicemia, and Alzheimer's Dementia. Review of the initial Minimum Data Set (MDS) assessment dated 07/16/15, revealed the resident's daily decision-making capabilities were intact which indicated Resident #4 was interviewable. The resident's vision was assessed as moderately impaired. Resident #4's activity preferences were as follows: doing things with groups of people, going outside, music, news, reading, animals, and participating in religious services or practices. The activities participation log had the following activities listed as attended by Resident #4: Bingo on 10/02/15 and 11/09/15; Games on 10/22/15; Group Discussion on 09/01/15, 10/01/15, and 10/09/15; One on One on 09/03/15, 09/09/15, 09/14/15, 11/09/15, 11/13/15, and 11/17/15.</p> <p>Observation of Resident #4 on 12/02/15, at 10:25 AM, revealed the resident was observed to be sitting on the side of the bed with a somber expression.</p> <p>Interview with Resident #4 on 12/02/15 at 10:25 AM revealed he/she enjoyed having the Bible read to him/her or reading a large-print Bible. The resident stated he/she had difficulty with his/her vision and had very little to do to keep him/her occupied and felt depressed. Resident #4 also stated he/she would love someone to visit with him/her. The resident revealed he/she was not aware of what activities were provided in the facility. Resident #4 stated staff did not provide one to one activities with him/her and he/she would love for staff to come in his/her room and visit. The resident stated he/she did not attend any group activity due to his/her vision</p>	F248	<p>The Activities Director will update the resident's Activity Program according to preference results from these meetings/MDS Assessment to ensure resident's preferences/needs are met and current, with focus on the hearing and visually impaired residents. Facility Staff, including Administrative Staff and Activity Staff, was educated on 12/10/15 by the Executive Director regarding the need for providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident, with focus on residents who are hearing and/or visually impaired. This in-service will be repeated on 1/14/16 by the Executive Director to ensure Facility Staff is educated. Newly-hired Activities Staff will be educated by the Activities Director during their orientation period regarding the need for providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident, with focus on residents who are hearing and/or visually impaired.</p> <p><u>Mentoring</u></p> <p>Activities Director will conduct a monthly audit to ensure residents' Activity Program remains appropriate for meeting the individual resident's needs and preferences. Activities Director will report the facility residents' general planned activities, modified activities, or special Activities Program to the monthly Quality Assurance Performance Improvement Committee for review and recommendations to ensure the facility is providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p>		

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F 248	<p>Continued Impairment.</p> <p>2. Review of Resident #13's medical record revealed the facility admitted the resident on 08/31/06 with diagnoses that included Stage IV Breast Cancer, Dementia, and Chronic Kidney Disease. Review of the annual Minimum Data Set (MDS) assessment dated 02/12/16, revealed the resident's daily decision-making capabilities were intact which indicated Resident #13 was interviewable. The MDS also revealed the resident had moderately impaired vision. The facility assessed Resident #13's activity preferences as follows: going outside, music, news, reading, and animals. Review of Resident #13's activity participation log dated November 2016, revealed staff had only read to Resident #13 two times, the resident attended Bingo one time, attended three religious services, attended one religious study, and eight group discussions. Review of Resident #13's care plan dated 02/20/15, revealed no interventions had been developed to address Resident #13's vision impairment and activities.</p> <p>Observation of Resident #13 on 12/02/16 at 6:16 AM revealed the resident was observed to be sitting in a wheelchair in the dining room awaiting his/her breakfast. The resident was observed to have a somber expression.</p> <p>Interview with Resident #13 on 12/02/16 at 6:16 AM revealed he/she did not have activities to keep him/her occupied. The resident stated he/she had difficulty with his/her vision and the facility did not have activities developed with consideration of his/her vision loss. Resident #13 stated he/she would love for staff to read to him/her or to visit with him/her. The resident</p>	F 248	The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	1/15/16

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	<p>Continued</p> <p>stated staff rarely read to or visited with him/her, and because he/she had difficulty seeing, he/she stayed bored and depressed. The resident stated he/she participated in Bingo, games, and church services at times.</p> <p>3. Review of Resident #15's medical record revealed the facility admitted the resident on 10/27/13, with diagnoses that included Depression, Osteoarthritis, and Peripheral Vascular Disease.</p> <p>Review of an annual Minimum Data Set (MDS) assessment completed by the facility for Resident #15 dated 09/09/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (SIMS) score of 14 which indicated the resident was independent with decision-making and therefore interviewable. The MDS also revealed the facility had assessed the resident's participation in religious services or practices to be of some importance to him/her. Review of the activities participation log for Resident #15 dated November 2015 revealed the resident participated in Bingo twice and one to one visits with staff eight times during the month.</p> <p>Observation of Resident #15 on 11/30/15 at 7:00 PM revealed the resident was observed to be up in a recliner with the television volume up very loud. The resident was observed to lower the volume and the surveyor had to speak extremely loud for the resident to hear.</p> <p>Interview conducted with Resident #15 on 12/03/15, at 1:00PM, revealed he/she had stopped going to Sunday school at the facility approximately one year ago because he/she could not hear well. Resident #15 revealed</p>	F 248			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NH6611

Facility ID: 100740

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

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FORM APPROVED  
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. DUREQID _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2016
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 248	<p>Continued</p> <p>he/she had been an active member of his/her church prior to the resident coming to live at the facility and missed his/her involvement in church. Resident #15 revealed he/she had told staff at the facility he/she had difficulty hearing.</p> <p>Interview conducted with Resident #15's family member on 12/03/15 at 8:00 PM revealed she had told facility staff Resident #15 had difficulty hearing and they needed to talk to the resident in his/her right ear. The family member stated Resident #15 had hearing difficulty for approximately ten years and had hearing aids but the resident refused to wear them. The family member stated Resident #15 had been very involved in church activities prior to coming to the facility and felt Resident #15 did not have enough activities and wished he/she had more to do.</p> <p>Interview conducted with the Activity Director on 12/03/15 at 8:05 PM revealed she was responsible for completing the assessments for Resident #4, Resident #13, and Resident #15 related to the residents' activity interests. The Activity Director revealed she felt Resident #4 and Resident #13 had enough activities and was unaware both residents wanted more time with staff visiting and reading to them. The Activity Director stated she was unaware Resident #4 and Resident #13 had vision difficulty. The Activity Director stated Resident #15 was not very interested in church activities, and had never told her why he/she had stopped attending Sunday school. The Activity Director also stated she did recall Resident #15's family member reporting to staff in a care plan meeting that the resident had difficulty hearing but she was unsure of the date of the meeting.</p> <p>Interview conducted with the Administrator on 12/03/15 at 8:16 PM revealed if a resident had hearing or vision problems, activities should be geared toward them and adjustments made to meet the resident's needs. The Administrator stated she had not identified any concerns with residents not receiving enough activities or activities not being adjusted for residents with vision or hearing impairment.</p>	F 248		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	<p><b>483.20(g) - 0) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b></p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p>	F 278	<p><b>Corrective Actions for Targeted Residents</b></p> <p>Resident #15's MDS was modified on 12/3/15 by the MDS Assessment Nurse Coordinator to reflect Resident #15's hearing loss. Resident #15's care plan was updated by the MDS Assessment Nurse Coordinator on 12/3/15 to reflect Resident #15's hearing loss. Resident #15's primary physician was notified by the Charge Nurse on 12/3/15 regarding Resident #15's potential hearing loss. Orders for a noise amplifying device were received for Resident #15 and ordered by the Activities Director.</p> <p><b>Identification of Other Residents with Potential to be Affected</b></p> <p>Residents with hearing loss have the potential to be affected by this practice. Beginning 12/3/15, current residents are to be interviewed for potential hearing loss by the MDS/PPS Reimbursement Clinician &amp; MDS Assessment Nurse Coordinator. These interviews will be completed by 1/14/16. Any residents found with hearing loss not coded on the MDS during these interviews will have their MDS modified and the care plan updated to reflect the resident's hearing loss by the MDS Coordinator. Resident's primary physician will be immediately notified of these findings by the Charge Nurse.</p> <p><b>Systematic Changes</b></p> <p>During the Quarterly MDS Assessment and Quarterly Care Plan Meeting, the MDS Nurses are to inquire from the Resident/Responsible Party of any potential hearing loss and code the MDS and update the care plan from the results of this interview. The resident's primary physician will be notified for follow-up should any unaddressed hearing loss be discovered during these interviews.</p> <p style="text-align: right;">Continued</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 278	<p>Continued</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to complete a Minimum Data Set (MDS) assessment to accurately reflect one (1) of eighteen (18) sampled residents' (Resident #15) status. Review of Resident #15's MDS revealed the facility had assessed the resident to have no difficulty in hearing. However, observations and interviews revealed Resident #15 had difficulty hearing.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 12/03/16, at 7:25PM, revealed the facility follows the Resident Assessment Instrument (RAI) related to accurately documenting for the Minimum Data Set (MDS).</p> <p>Review of Resident #15's medical record revealed the facility admitted the resident on 10/27/13, with diagnoses that included Depression and Peripheral Vascular Disease.</p> <p>Review of an annual Minimum Data Set (MDS) assessment for Resident #15 dated 09/09/15, revealed the facility had assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was independent with decision-making and therefore interviewable. The MDS revealed the facility had assessed Resident #15 to have no difficulty with hearing.</p>	F278	<p>Education for Nursing Staff, including the MDS Nurses, was conducted on 12/10/15 by the Executive Director regarding the need for nurses to notify the resident's primary physician should they become aware of a resident's unaddressed hearing loss. Education also includes the need to place this information on the 24-hour Report for communication to Administrative Staff for appropriate follow-up assessments and care planning for these residents. This in-service will be repeated on 1/14/16 by the Executive Director to ensure Nursing Staff is educated. Newly-hired Nursing staff, including MDS Nurses, will be educated by the Assistant Director of Nursing regarding the need for nurses to notify the resident's primary physician should they become aware of an unaddressed hearing loss and report these findings to the Administrative Staff.</p> <p><u>Monitoring</u></p> <p>A monthly audit will be conducted by the MDS Nurses focusing on unaddressed hearing loss to ensure accurate coding of the MDS is completed; as well as accurate documentation on the care plan regarding hearing issues. Results of this audit will be presented by the MDS Nurses to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then quarterly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	1/15/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2016
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 306 WEST MAPLE AVENUE LANCASTER, KY 40444	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued Observation of Resident #15 on 11/30/15, at 7:00 PM, revealed the resident was observed to be up in a recliner with the television volume up very loud. The resident was observed to lower the volume and the surveyor had to speak extremely loud for the resident to hear.  Interview conducted with Resident #15 on 12/03/16, at 1:00PM, revealed he/she had experienced hearing difficulty for about ten years and had told facility staff. The resident stated he/she had hearing aids but did not wear them.  Interview with the MDS Coordinator on 12/03/16, at 6:30 PM, revealed she was not aware Resident #15 had any hearing loss, and if Resident #15 had hearing loss it should have been coded as such on the MDS. The MDS Coordinator stated she was responsible for assessing and completing the MDS for Resident #15.  Interview conducted with the DON on 12/03/16, at 7:25PM, revealed she reviewed MDS assessments only if the MDS Coordinator was not there. The DON stated she had not identified any concerns with MDS accuracy in the facility.	F278		
F 279 SS'D	483.20(d), 483.20(k) (1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279	<u>Corrective Actions for Targeted Residents</u>  Resident #15's MDS was modified on 12/3/15 by the MDS Assessment Nurse Coordinator to reflect Resident #15's hearing loss. Resident #15's care plan was updated by the MDS Assessment Nurse Coordinator on 12/3/15 to reflect Resident #15's hearing loss. Resident #15's primary physician was notified by the Charge Nurse on 12/3/15 regarding Resident #15's potential hearing loss. Orders for a noise amplifying device were received for Resident #15 and ordered by the Activities Director.	

FORM CMS-2567(02-99) Previous Versions Obsolete

EventID: 1116511

FacilityID: 100719

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 279	<p>Continued assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.26; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10 (b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to develop a comprehensive plan of care for one (1) of eighteen (18) sampled residents (Resident #15) related to hearing loss. Review of the comprehensive plan of care for Resident #15 revealed no interventions had been developed to address the resident's hearing impairment.</p> <p>The findings include:</p> <p>Review of a facility policy titled, "Care Plans," with a revision date of July 2014, revealed a preliminary and comprehensive plan of care would be developed that included measurable objectives and timetables to meet the resident's medical, mental, recreational, spiritual, and psychosocial needs. The comprehensive care plan would be developed for each resident using an interdisciplinary team in cooperation with the resident and his/her family or representative.</p> <p>Review of the medical record for Resident #15 revealed the facility admitted the resident on</p>	F279	<p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Residents with hearing loss have the potential to be affected by this practice. Beginning 12/3/15, current residents are to be interviewed for potential hearing loss by the MDS/PPS Reimbursement Clinician &amp; MDS Assessment Nurse Coordinator. These interviews will be completed by 1/14/16. Any residents found with hearing loss not coded on the MDS during these interviews will have their MDS modified and the care plan updated to reflect the resident's hearing loss by the MDS Coordinator. Resident's primary physician will be immediately notified of these findings by the Charge Nurse.</p> <p><u>Systematic Changes</u></p> <p>During the Quarterly MDS Assessment and Quarterly Care Plan Meeting, the MDS Nurses are to inquire from the Resident/Responsible Party of any potential hearing loss and code the MDS and update the care plan from the results of this interview. The resident's primary physician will be notified for follow-up should any unaddressed hearing loss be discovered during these interviews. Education for Nursing Staff, including the MDS Nurses, was conducted on 12/10/15 by the Executive Director regarding the need for nurses to notify the resident's primary physician should they become aware of a resident's unaddressed hearing loss. Education also includes the need to place this information on the 24-hour Report for communication to Administrative Staff for appropriate follow-up assessments and care planning for these residents.</p> <p style="text-align: right;">Continued</p>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J16511

Facility ID: 100719

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(5) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X4) COMPLETION DATE
F 270	<p>Continued</p> <p>10/27/13, with diagnoses that included Depression, Peripheral Vascular Disease, and Osteoarthritis.</p> <p>Review of an annual Minimum Data Set (MDS) assessment completed by the facility for Resident #15 dated 09/09/15, revealed the facility had assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was independent with decision-making and therefore interviewable.</p> <p>Review of the comprehensive plan of care for Resident #15 dated 09/24/15, revealed no interventions had been developed to address Resident #15's hearing loss.</p> <p>Observation on 11/30/15, at 7:00PM, revealed Resident #15 was observed to be up in a recliner with the television volume up very loud. The resident was observed to lower the volume and the surveyor had to speak extremely loud for the resident to hear.</p> <p>Interview conducted with Resident #15 on 12/03/15, at 1:00PM, revealed he/she had the television up loud because he/she had difficulty hearing. The resident requested the surveyor to speak loudly so he/she could hear. Resident #15 stated he/she had stopped going to Sunday school at the facility approximately one year ago because he/she could not hear well. Resident #15 revealed he/she had been an active member of his/her church prior to the resident coming to live at the facility and missed his/her involvement in church. Resident #15 revealed he/she had told staff at the facility he/she had difficulty hearing.</p> <p>Interview conducted with the Activity Director on</p>	F270	<p>This in-service will be repeated on 1/14/16 by the Executive Director to ensure Nursing Staff is educated. Newly-hired Nursing staff, including MDS Nurses, will be educated by the Assistant Director of Nursing regarding the need for nurses to notify the resident's primary physician should they become aware of an unaddressed hearing loss and report these findings to the Administrative Staff.</p> <p><u>Monitoring</u></p> <p>A monthly audit will be conducted by the MDS Nurses focusing on unaddressed hearing loss to ensure accurate coding of the MDS is completed; as well as accurate documentation on the care plan regarding hearing issues. Results of this audit will be presented by the MDS Nurses to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then quarterly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	1/15/16

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Event ID: IH5611

Facility ID: 100719

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

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OMS NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  183065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  1210312015
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	<p>Continued</p> <p>12103115, at 6:05PM, revealed she was responsible for completing the assessment for Resident #15 related to activity interests. The Activity Director stated Resident #15 was not very interested in church activities. The Activity Director stated Resident #15 had never told her why he/she had stopped attending Sunday school. The Activity Director stated she recalled Resident #15's family member reporting to staff in a care plan meeting that the resident had difficulty hearing.</p> <p>Interview with the MDS Coordinator on 12/03/15, at 8:30PM, revealed she was not aware Resident #15 had any hearing loss, and if Resident #15 had hearing loss, a care plan should have been developed to address the resident's hearing loss. The MDS Coordinator stated she was responsible for developing the comprehensive plan of care for Resident #15.</p> <p>Interview conducted with Resident #15's family member on 12/03/15, at 7:15PM, revealed she had informed facility staff several times that Resident #15 had difficulty hearing and they needed to talk to the resident in his/her right ear. The family member stated Resident #15 had hearing difficulty for approximately ten years and had hearing aids but the resident had refused to wear them.</p> <p>Interview conducted with the DON on 12/03/15, at 7:25 PM, revealed she reviewed care plans randomly, and had not identified any concerns with care plans at the facility.</p> <p>Interview conducted with the Administrator on 12/03/15, at 8:15PM, revealed if a resident had hearing or vision problems, care plan</p>	F 279		

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Event ID:116411

Facility ID: 160718

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2016
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279  F 282 SS-D	<p>Continued</p> <p>Interventions should have been developed to address the resident's hearing loss.</p> <p><b>403.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>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 follow the written plan of care for two (2) of eighteen (18) sampled residents (Resident #12 and Resident 14). Review of the medical record revealed Resident #12 required tray setup for meal service. However, observation of Resident #12 on 12/03/15 at 12:45 PM revealed he/she was attempting to cut up the meat on his/her plate. Record review revealed the facility had assessed Resident #14 to be incontinent of bowel and bladder. The resident's comprehensive care plan addressed the resident's incontinence with interventions for staff to offer the resident assistance with toileting and/or provide incontinence care. However, the facility failed to provide incontinence care for four and one-half (4 1/2) to five and one-half (5 1/2) hours on 12/03/15.</p> <p>The findings include:</p> <p>Review of facility policy titled "Providing Care and Services According to Plan of Care" with a revision date of September 2008 revealed the</p>	F 282	<p><u>Corrective Actions for Targeted Residents</u></p> <p>Resident #12 has shown no ill-effects from cited practice; and in fact, has gained weight at the facility. Certified Medication Aide who delivered the tray to Resident #12 was counseled by Director of Nursing on 12/4/15 regarding the appropriate procedure for tray set-up during meal service, to include cutting meat for residents unable to do so themselves. State Registered Nurse's Aide #3 was counseled on 12/3/15 by the Director of Nursing regarding the appropriate procedure and timeframe for performing incontinence care, per Resident #14's Care Plan.</p> <p>1:1 and group education was initiated by Administrative Nurses on 12/7/15 for Nursing Staff regarding proper meal tray set-up based on individual resident needs and per the resident's Care Plan. This education included providing incontinence care every 2 hours for residents who are incontinent of bladder and/or bowel, per the resident's Care Plan and per Facility Policy.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Residents requiring assistance with meal tray set-up have the potential to be affected by this practice. Observation of meal tray set-up will be conducted on a daily basis by Administrative Staff assigned to the Dining Room each day. Consultant Registered Dietician will observe the Dining Program as well as hallway tray set-up at least monthly during her/his compliance visits.</p> <p>Residents who are incontinent of bladder and/or bowel have the potential to be affected by this practice. 1:1 and group education was initiated by Administrative Nurses on 12/7/15 for Nursing Staff regarding providing incontinence care every 2 hours for residents who are incontinent of bladder and/or bowel, per the resident's Care Plan and per Facility Policy.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 282	<p>Continued</p> <p>facility would provide effective care, treatment, and services to meet each resident's needs holistically and according to the Plan of Care for care, treatment, and services. Continued review of facility policy revealed basic needs were determined by written facility policies and individualized care plans in compliance with current regulations and physician's orders.</p> <p>1. Observation of Resident #12 on 12/03/15 at 12:45 PM revealed Resident #12 to be sitting in his/her wheelchair with his/her left arm in a sling. Continued observation of Resident #12 revealed he/she was attempting to cut up meat that was on his/her plate with a fork with no success. Further observation revealed a visitor of Resident 12's roommate came over and cut up Resident #12's meat for him/her.</p> <p>Review of Resident #12's record revealed the facility admitted Resident #12 on 11/25/15 with diagnoses including Dementia, Abnormal Weight Loss, Anemia, Protein-Calorie Malnutrition, and a Left Arm Fracture. Review of Resident #12's Nurse Aide care plan, undated, revealed Resident #12 to be independent for eating with tray setup required. Review of Resident #12's Nutrition Risk Assessment dated 12/01/15 revealed Resident #12 to have weight loss trends. Continued review of Resident #12's Nutritional Risk Assessment revealed Resident #12 had a current weight of 80.0 pounds and that Resident #12's Ideal Weight Range (IWR) should be between 99 pounds and 121 pounds. Further review of Resident #12's Nutrition Risk Assessment revealed Resident #12 had been assessed to be at high risk for malnutrition/weight loss.</p> <p>Interview with the Certified Medication Aide</p>	F282	<p><u>Systematic Changes</u></p> <p>Mandatory in-service was conducted for the Nursing Staff on 12/10/15 by the Executive Director and Director of Nursing regarding providing care and services according to the resident's plan of care. This includes proper meal tray set-up based on individual resident needs, to include cutting meat for residents unable to do so themselves. This education also included providing incontinence care every 2 hours for residents who are incontinent of bladder and/or bowel, per the resident's Care Plan and per Facility Policy. This in-service will be repeated by the ED and DON on 1/14/16 to ensure Nursing Staff is educated. Newly-hired Nursing Staff will be educated by his/her preceptor during their orientation period regarding providing care and services according to the resident's plan of care. This includes proper meal tray set-up based on individual resident needs and per the resident's Care Plan. This education will also include providing incontinence care every 2 hours for residents who are incontinent of bladder and/or bowel, per the resident's Care Plan and per Facility Policy.</p> <p><u>Monitoring</u></p> <p>Director of Nursing will conduct weekly observation audits of 10% of resident population for meal tray set-up, based on the resident's individual needs and per the resident's Care Plan. Director of Nursing will conduct weekly observation audits of staff performing incontinence care with focus on the time-frame of this care being provided every 2 hours, per the resident's Care Plan and per Facility Policy.</p> <p>Continued</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 282	<p>Continued</p> <p>(CMA) on 12/03/15 at 2:14 PM revealed she had delivered Resident #12's meal tray to him/her during the lunch meal service. Continued interview with the CMA revealed she had not cut up Resident #12's meal when she had delivered the lunch meal tray. Further interview with the CMA revealed she had been trained to cut up a resident's meal when performing meal tray setup and forgot to do it when she had passed Resident #12's lunch tray.</p> <p>Interview with Registered Nurse (RN) #2 (who was the Unit Manager on Resident #12's hall) on 12/03/15 at 3:14PM revealed Certified Nurse Aides/Certified Medication Aides were to look at each resident's Nurse Aide care plan daily to determine what level of assistance a resident required for eating. Continued interview with RN #2 revealed she would expect a staff member passing a meal tray to cut up a resident's meal if they required tray setup assistance. RN #2 stated that she conducted a daily round to ensure nurse aides were providing proper care to residents and had not identified any concerns.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 12/03/15 at 3:18 PM revealed that the main thing to ensure during resident tray setup was that the residents' meals were cut up. Continued interview with LPN #1 revealed she would expect all nurse aides to review each resident's Nurse Aide care plan daily in order to determine how much assistance a resident required for feeding/eating. Further interview with LPN #1 revealed she conducted checks daily in order to ensure that residents were receiving proper care and had not identified any issues.</p> <p>Interview with the facility Director of Nursing</p>	F282	<p>DON will present the results of these audits to the monthly Quality Assurance Performance Improvement Committee for review and recommendations to ensure care and services are being provided according to the resident's plan of care until desired threshold of 100% compliance is met for 3 consecutive months; then monthly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MOS Coordinator.</p>	1/15/16

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Event ID: J16511

Facility ID: 100710

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

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STATEMENT OF DEFICIENCIES AND Plan OF CORRECTION?	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015	
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(X4) JD 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 282	<p>Continued</p> <p>(DON) on 12/03/15 at 7:40 PM revealed that nurse aides should look at the Nurse Aide Care Plan in order to determine how much assistance a resident needs with eating. Continued interview with the DON revealed she would expect to see a nurse aide providing tray setup to remove lids, open drinks, open eating utensils, and cut up any meats that needed to be cut up. Further interview with the DON revealed she did not conduct audits to ensure that proper care was being provided, but the unit managers did go behind the nurse aides to ensure that they were providing proper care.</p> <p>2. Review of Resident #14's medical record revealed the facility admitted the resident on 06/07/13 with diagnoses of difficulty in walking, general symptoms, malaise and fatigue, Obesity non other specified, chronic airway obstruction, Osteoarthritis, and allied disorders.</p> <p>Review of the Comprehensive Care Plan for Resident #14, last reviewed and revised on 11/23/15, revealed staff was required to assist the resident with toileting as needed.</p> <p>Interview with Resident #14 on 12/3/12 at 12:55 PM revealed the resident had not been changed or assisted with toileting since early this morning around 7:00AM. Resident #14 stated, "I have not asked to be changed but I should not have to."</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 12/03/15 at 2:37PM revealed that he/she last changed Resident #14 around 9:00 AM during his/her morning rounds and that he/she normally will change the resident again during shower time and if not then he/she will only</p>	F 282		

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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:  185066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(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)	LSC COMPLETION DATE	
F 282	<p>Continued</p> <p>change/check on residents when they request or after lunch. Further interview revealed that residents should be checked every two hours and as needed.</p> <p>Interview with the Assessment Coordinator on 12/03/15 at 7:25PM revealed they are responsible for developing/revising the plan of care and that perineal care should be provided with each incontinence episode and residents should be checked on every two hours with rounding. The Assessment Coordinator stated she felt four and one-half hours is too long to wait to be toileted/changed.</p> <p>Interview with the Director of Nursing on 12/03/15 at 7:26 PM revealed that per facility policy they are to do routine rounding but it does not specify how often residents should be checked on. "We try to check on residents every two hours and no more than three hours should pass. Further interview revealed that she felt that four and one-half hours was too long to wait to be toileted or changed.</p> <p>Interview with the Administrator on 12/03/15 at 8:45PM revealed that per policy they have routine rounding and that the resident should be checked on every two hours. Further investigation revealed that how long the resident waits to be changed/toileted depends on the resident and the Administrator could not state whether or not four and one-half hours was too long a wait for Resident #14.</p>	F 282			

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Event ID: IH6511

Facility ID: 100719

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/OWA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 312 SS=D	<p>403.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>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 provide the necessary assistance for two (2) of eighteen (18) sampled residents (Residents #12 and #14) related to meal tray setup and incontinence care. Review of Resident #12's medical record revealed Resident #12 had been assessed by the facility to require tray setup for meal service. However, observation of Resident #12 on 12/03/15 at 12:46 PM revealed facility staff failed to provide tray setup and cut up the meat on the resident's meal tray. Resident #12 was attempting to cut up the meat on his/her plate without success. Review of the medical record for Resident #14 revealed the resident had been assessed by the facility to be incontinent of bladder and require two (2) persons for assistance for toileting. However, observation and interview of Resident #14 on 12/03/15 at 12:55 PM revealed facility staff failed to do routine rounding and the resident had not been assisted with toileting or provided incontinence care since 7:00AM. Review of the facility policy titled "Perineal Care," dated 09/08, revealed that care will be provided as needed.</p> <p>The findings include:</p> <p>1. Review of facility policy titled "Nursing Department Responsibilities at Mealtime," updated December 2010, revealed it was the</p>	F 312	<p><u>Corrective Actions for Targeted Residents</u></p> <p>Resident #12 has shown no ill-effects from cited practice; and in fact, has gained weight at the facility. Certified Medication Aide who delivered the tray to Resident #12 was counseled by Director of Nursing on 12/4/15 regarding the appropriate procedure for tray set-up during meal service, to include cutting meat for residents unable to do so themselves. State Registered Nurse's Aide #3 was counseled on 12/3/15 by the Director of Nursing regarding the appropriate procedure and time-frame for performing incontinence care, per Resident #14's Care Plan.</p> <p>1:1 and group education was initiated by Administrative Nurses on 12/7/15 for Nursing Staff regarding providing the necessary services for residents dependent on staff for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene. This includes meal tray set-up based on individual resident needs and per the resident's Care Plan. This education included providing incontinence care every 2 hours for residents who are incontinent of bladder and/or bowel, per the resident's Care Plan and per Facility Policy.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Residents who are unable to carry out activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene have the potential to be affected by this practice. Observation of meal tray set-up will be conducted on a daily basis by Administrative Staff assigned to the Dining Room each day. Consultant Registered Dietician will observe the Dining Program as well as hallway tray set-up at least monthly during her/his compliance visits.</p> <p style="text-align: right;">Continued</p>	

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Event ID: 116611

Facility ID: 400718

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 312	<p>Continued</p> <p>responsibility of the Nursing Department to distribute meal trays to resident rooms. Continued review of the facility policy revealed it was the responsibility of the Nursing Department to assist residents who were unable to feed themselves. Further review of facility policy revealed the nursing staff was to cut up meat, butter bread, and assist where needed during meal service.</p> <p>Observation of Resident #12 on 12/03/15 at 12:46 PM revealed Resident #12 to be sitting in his/her wheelchair with his/her left arm in a sling. Continued observation of Resident #12 revealed he/she was attempting to cut up the meat that was on his/her plate with a fork with no success. Further observation revealed a visitor of Resident #12's roommate came over and cut up Resident #12's meat for him/her.</p> <p>Review of Resident #12's record revealed the facility admitted Resident #12 on 11/25/15 with diagnoses including Dementia, Abnormal Weight Loss, Anemia, Protein-Calorie Malnutrition, and a Left Arm Fracture. Review of Resident #12's Nurse Aide care plan, undated, revealed Resident #12 to be independent for eating with tray setup required. Review of Resident #12's Nutrition Risk Assessment dated 12/01/15 revealed Resident #12 to have weight loss trends and to need assistance with dining. Continued review of Resident #12's Nutritional Risk Assessment revealed Resident #12 had a current weight of 89.9 pounds and that Resident #12's Ideal Weight Range (IWR) should be between 99 pounds and 121 pounds. Further review of Resident #12's Nutrition Risk Assessment revealed Resident #12 had been assessed to be at high risk for malnutrition/weight loss.</p>	F 312	<p>Residents who are incontinent of bladder and/or bowel have the potential to be affected by this practice. 1:1 and group education was initiated by Administrative Nurses on 12/7/15 for Nursing Staff regarding providing incontinence care every 2 hours for residents who are incontinent of bladder and/or bowel, per the resident's Care Plan and per Facility Policy.</p> <p><u>Systematic Changes</u></p> <p>Mandatory in-service was conducted for the Nursing Staff on 12/10/15 by the Executive Director and Director of Nursing regarding providing the necessary services for residents dependent on staff for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene. This includes proper meal tray set-up based on individual resident needs, to include cutting meat for residents unable to do so themselves. This education also included providing incontinence care every 2 hours for residents who are incontinent of bladder and/or bowel, per the resident's Care Plan and per Facility Policy. This in-service will be repeated by the ED and DON on 1/14/16 to ensure Nursing Staff is educated. Newly-hired Nursing Staff will be educated by his/her preceptor during their orientation period regarding providing the necessary services for residents dependent on staff for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p><u>Monitoring</u></p> <p>Director of Nursing will conduct weekly observation audits of meal tray set-up in the Dining Room and on the hallway to ensure compliance based on individual resident needs.</p> <p>Continued</p>	

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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:  185085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 312	<p>Continued</p> <p>Interview with the Certified Medication Aide (CMA) on 12/03/15 at 2:14PM revealed she had delivered Resident #12's meal tray to him/her during the lunch meal service. Continued Interview with the CMA revealed she had not cut up Resident #12's meal when she delivered the lunch meal tray. Further Interview with the CMA revealed she had been trained to cut up a resident's meal when performing meal tray setup and forgot to do it when she had passed Resident #12's lunch tray.</p> <p>Interview with Registered Nurse (RN) #2 (who was the Unit Manager on Resident #12's hall) on 12/03/15 at 3:14 PM revealed she would expect a staff member passing a meal tray to cut up a resident's meal if they required tray setup assistance. RN #2 stated that she conducted a daily round to ensure nurse aides were providing proper care to residents and had not identified any concerns.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 12/03/15 at 3:18PM revealed that the main thing to ensure during resident tray setup was that the residents' meals were cut up. Further Interview with LPN #1 revealed she conducted checks daily in order to ensure that residents had received proper care and had not identified any issues.</p> <p>Interview with the facility Director of Nursing (DON) on 12/03/15 at 7:40PM revealed she expected to see a nurse aide providing tray setup to remove lids, open drinks, open eating utensils, and cut up any meals that needed to be cut up. Further interview with the DON revealed she did not conduct audits/rounds to ensure that proper</p>	F 312	<p>Director of Nursing will conduct weekly observation audits of 10% of nursing staff performing Incontinence care with focus on the time-frame of this care being provided every 2 hours, per the resident's Care Plan and per Facility Policy. DON will present the results of these audits to the monthly Quality Assurance Performance Improvement Committee for review and recommendations- to ensure the facility is providing the necessary services for residents dependent on staff for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene- until desired threshold of 100% compliance is met for 3 consecutive months; then monthly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	1/15/16

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Event ID: 116611

Facility ID: 100719

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IS PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	<p>Continued</p> <p>care was being provided, but the unit managers went behind the nurse aides to ensure that they had provided proper care.</p> <p>2. Review of the facility policy titled "Personal Care," dated 09/08, revealed that care would be provided as needed.</p> <p>Review of Resident #14's medical record revealed the facility admitted the resident on 06/07/13 with diagnoses of difficulty in walking, general symptoms, malaise and fatigue, Debility non other specified, chronic airway obstruction, and Osteoarthritis. Review of the MDS dated 11/04/15 revealed that the resident required the extensive assistance of two persons with toileting and was frequently incontinent of bladder.</p> <p>Review of the Comprehensive Care Plan for Resident #14, last reviewed and revised on 11/23/15, revealed staff was required to assist the resident with toileting as needed.</p> <p>Interview with Resident #14 on 12/03/12 at 12:55 PM revealed the resident had not been changed or assisted with toileting since early that morning around 7:00AM. Resident #14 stated, "I have not asked to be changed, but I should not have to."</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 12/03/15 at 2:37PM revealed that she had provided incontinence care for Resident #14 around 9:00AM during morning rounds. SRNA #3 said she normally would change the resident again during shower time. According to the SRNA, if she did not change the resident during shower time then she would only change/check on residents when they request or</p>	F 312		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  D. WING _____		(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(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)	DATE COMPLETION DATE	
F 312	Continued after lunch. Further interview revealed residents should be checked every two hours and as needed.  Interview with the DON 12/03/15 at 7:26PM revealed that per facility policy staff was to conduct routine rounds but the policy did not specify how often residents should be checked on. The DON stated, "We try to check on residents every two hours and no more than three hours should pass." Further interview revealed she felt that four and one-half hours was too long to wait to be toileted or changed.  Interview with the Administrator on 12/03/15 at 8:45 PM revealed per policy staff was to complete routine rounds with staff checking on residents every two hours. The Administrator stated how long the resident waits to be changed/toileted depends on the resident and the Administrator could not say whether or not four and one-half hours was too long a wait for Resident #14.	F 312			
F 323 SS E	403.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined the facility failed	F 323	<u>Corrective Actions for Targeted Residents</u>  Maintenance Director removed unlocking mechanism from key pad lock for the cited DME cleaning room on 11/30/15. Frayed pull-cord in the bathroom at DME cleaning area was repaired by the Maintenance Director on 12/4/15. Maintenance Director installed a store room lock on the cited Central Supply Room door on 12/5/15.  <u>Identification of Other Residents with Potential to be Affected</u>  Maintenance Director removed unlocking mechanism from all key pad locks throughout the facility on 11/30/15. Areas with key pad locks can now only be accessed by code or key and doors automatically lock when closed.  <u>Systematic Changes</u>  Facility Staff was educated on 12/10/15 by the Executive Director regarding the procedure for notifying Maintenance Department of any faulty locks found in the facility. This in-service will be repeated on 1/14/16 by the Executive Director to ensure Facility Staff is educated. Newly-hired Facility Staff will be educated by the Maintenance Director regarding the procedure for notifying Maintenance Department of any faulty locks found in the facility. Hazardous Area/Supply Room doors will be checked daily by Housekeeping Staff during routine daily cleaning. Any door lock issues will be reported to the Maintenance Director immediately.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/103/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(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	<p>Continued</p> <p>ensure the residents' environment was free from accident hazards. Observation on 11/30/15 and 12/03/15 revealed two (2) often (10) storage areas which contained items hazardous to residents to be unlocked. These areas were accessible to residents. The DME cleaning room (Central Supply) on the HSC Hall was observed to be unlocked on 11/30/16 at 7:08PM and on 12/03/15 at 12:51 PM. This room contained numerous syringes with needles and a restroom with exposed wires. Observation of the janitor closet on the EUC hall on 11/30/15 revealed the door was unlocked and this room contained chemicals that could be hazardous to residents if ingested.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Precautions-Central Supply/Stockroom," with a revised date of July 1990, revealed the Central Supply door should be locked at all times.</p> <p>Review of the facility's policy titled "Chemical Storage and Disposal," revealed, "Many hazards can occur from chemicals stored improperly such as unauthorized access to chemicals, incompatible chemicals, temperature sensitive chemicals, container corrosion, etc. It is the policy of the facility to ensure hazardous chemicals are properly stored, maintained and disposed of in an approved manner."</p> <p>1. Observation of the DME cleaning room (Central Supply) on 11/30/15 at 7:08PM revealed the door to be unlocked and the following sharps items to be present and accessible to wandering residents: 22 blood collection needles, one Huber needle set (needle used to access ports</p>	F 323	<p><u>Monitoring</u></p> <p>The Executive Director will complete weekly audits of the Hazardous Area/Supply Room door to ensure security. The results of these audits will be presented by the ED to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 4 consecutive weeks; then quarterly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	1/15/16	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event JDUN5511

Facility ID: 100710

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVAY COMPLETED  12/03/2015
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued</p> <p>implanted under the skin of chronically ill patients), two boxes of 100-count insulin syringes with needles, one box of 100 tuberculin safety syringes with needles, three boxes of 100-count tuberculin hypodermic syringes with needles, two boxes of 100-count various sized syringes with needles, two boxes of 100-count hypodermic syringes with needles, and five boxes of 100-count various sized safety needles. Continued observation of the DME cleaning area revealed a restroom with an emergency pull cord hanging from the wall with wires exposed. Observation on 12/03/15 at 12:51 PM revealed the door to the DME cleaning room (Central Supply) to be unlocked and accessible to wandering residents.</p> <p>Interview with the Maintenance Director (MD) on 12/03/15 at 2:20 PM revealed he had left the door unlocked on 12/03/15 prior to the observation made at 12:51 PM. Continued interview with the MD revealed he had been doing a walk-thru with another state surveyor and had forgotten to make sure that the door was locked. Further interview with the MD revealed the door should have been locked and that it is to be locked at all times.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 12/03/15 at 3:04PM revealed the SRNAs do not have access to the DME cleaning room (Central Supply) and that if they need supplies from the room they have to contact the nurse or supply clerk in order to get supplies.</p> <p>Interview with SRNA #2 on 12/03/15 at 3:08 PM revealed she did not have access to the DME cleaning room (Central Supply) and that if she needed to get supplies the Maintenance Director and the supply clerk have keys and could let her</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  1210312015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	

(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	<p>Continued</p> <p>in to get supplies.</p> <p>Interview with Registered Nurse (RN) #1 on 12103115 at 3:08PM revealed the DME cleaning room (Central Supply) was to be locked at all times and she was not aware of the door ever being unlocked. Continued interview with RN #1 revealed she had observed residents to wander down the HSC hallway where the DME cleaning room (Central Supply) room was located.</p> <p>Interview with the Director of Nursing (DON) on 12103/15 at 7:35PM revealed the DME cleaning room (Central Supply) room door should never be unlocked when unattended. Continued interview with the DON revealed she had observed residents to wander down the HSC hallway. Further interview with the DON revealed the supply clerk and Housekeeping both check the DME cleaning room (Central Supply) door to ensure it is locked. The DON said she was not aware of the door being unlocked. Further interview with the DON revealed that the door being unlocked could have been a potential hazard to the facility's wandering residents.</p> <p>Interview with the Administrator on 12103/15 at 7:40 PM revealed the door to the DME cleaning room (Central Supply) should be locked at all times. Continued interview with the Administrator revealed she conducted weekly safety checks throughout the facility to include checking the DME cleaning room (Central Supply) to ensure it was locked and had not identified the door to be left unlocked in the past.</p> <p>2. Observation conducted on 11130/15 at 7:03 PM revealed a Janitor Closet door on the ECU unit was found to be unlocked; the closet</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(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 contained four 1-gallon containers of glass cleaner, lemon sanitizer, bleach, and floor cleaner.  Interview conducted with the Director of Environmental Services on 11/30/16 at 7:05 PM revealed that she was unaware that the Janitor Closet was unlocked, it is supposed to be locked at all times. She said that someone must have bumped the lock on the inside of the door and unlocked it, but this is the only time she had observed it unlocked.  Interview conducted with the Maintenance Director on 11/30/15 at 7:30PM revealed he had never seen the Janitor Closet door unlocked but he was removing the lock switch on all the closet doors so they could not be accidentally unlocked again.  An interview conducted with the Executive Director on 12/03/15 at 8:17PM revealed that the Janitor Closet doors should never be unlocked, and did not know why it would have been unlocked.	F 323			
F 371 SS=E	483.35(l) 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	F 371	<u>Corrective Actions for Targeted Residents</u>  Facility residents have shown no ill effects by this practice. Cited Robot Coupe Blixer was disassembled and sanitized by Maintenance Director and Dietary Manager on 11/30/15.  Dietary Manager was counseled on 12/8/15 by the Executive Director regarding the need to maintain kitchen equipment, including cleaning and sanitizing, per manufacturer's recommendations.  <u>Identification of Other Residents with Potential to be Affected</u>  Current residents have the potential to be affected by this practice. Back up blade received and used in rotation with current blade assembly beginning on 12/4/15. Tool to enable easier blade disassembly of Robot Coupe Blixer arrived at facility on 12/7/15.  <u>Systematic Changes</u>  Robot Coupe Blixer is being disassembled and cleaned/sanitized daily, per manufacturer's recommendations, by Dietary Staff beginning 11/30/15. Daily cleaning and sanitation of the Robot Coupe Blixer is documented on a daily cleaning/sanitation log by Dietary Staff beginning 11/30/15.  Continued		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H6511

Facility ID: 100719

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(K3) DATE SURVEY COMPLETED  1210312015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 368 WEST MAPLE AVENUE LANCASTER, KY 40444	
(K4) 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)	(K5) COMPLETION DATE
F 371	<p>Continued</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility policies, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for eighty-five (85) of eighty-eight (88) residents of the facility who received nutrition from the kitchen. Observation's on 11/30/15 revealed the kitchen staff was not cleaning the "Robot-Coupe Blixer" (a food processor used to puree and grind food) blade per manufacturer recommendations.</p> <p>The findings include:</p> <p>Interview with the Dietary Manager (DM) on 12/03/15 at 4:07 PM revealed that the facility does not have a policy for cleaning the Robot-Coupe Blixer.</p> <p>Review of the "Operation Manual for Robot Coupe Blixer," dated 08/2009, revealed, "The blade assembly should be taken completely apart and washed after each day's use for sanitary reasons."</p> <p>Observation and interview on 11/30/15 at 6:51 PM with the DM revealed the facility had a Robot Coupe Blixer. The DM stated that staff washed the Robot Coupe Blixer every day after each use. The DM stated the Maintenance Director took the device to his office, took it apart, and cleaned it about once a month. The Maintenance Director took the blade assembly apart per request and a grey, green, and black substance slowly flowed out of the assembly. Further observation</p>	F 371	<p>Dietary Staff was educated by the Dietary Manager regarding following the manufacturer's recommendations for cleaning and sanitizing the Robot Coupe Blixer beginning 12/7/15. This education was completed on 12/11/15 to ensure Dietary Staff is educated. Contracted Registered Dietician will conduct Sanitation Audits, to include cleaning/sanitizing kitchen equipment per manufacturer's recommendations, with each compliance visit.</p> <p>Newly-hired Dietary Staff will be educated by the Dietary Manager during their orientation period regarding following the manufacturer's recommendations for cleaning and sanitizing kitchen equipment, to include the Robot Coupe Blixer.</p> <p style="text-align: center;"><u>Monitoring</u></p> <p>An audit of the cleaning and sanitation of the Robot Coupe Blixer, as well as compliance of documentation on the daily cleaning/sanitization log, will be conducted by the Dietary Manager weekly. The results of these audits will be presented by the DM to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 4 consecutive weeks; then monthly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	1/15/16

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Facility ID: 100710

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2016
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued revealed a thick coating of food particles on the walls of the center assembly.  Interview with the Maintenance Director on 12/03/15 at 7:30 PM revealed he took the blade assembly apart about once a month, cleaned, and sanitized it. The Maintenance Director said he was not aware the machine should be taken apart every day.  Interview with the Dietary Manager on 12/03/15 at 4:07 PM revealed she was not aware the Robot Coupe Blade assembly should be taken apart every day. The Dietary Manager stated she had not read the instruction manual.	F 371		
F 411 SS"E	483.65(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS  The facility must assist residents in obtaining routine and 24-hour emergency dental care.  A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on interview and record review and review of facility policy, it was determined the facility	F 411	<u>Corrective Actions for Targeted Residents</u> Residents #2, #6, #8, and Resident #15 have presented with no issues concerning his/her oral cavity and will receive a dental evaluation on 1/8/16 by contracted dental service.  <u>Identification of Other Residents with Potential to be Affected</u> Residents who have not had an annual evaluation by a dental service have the potential to be affected by this practice. A list of facility residents who have not received an annual dental evaluation was developed by the Social Service Director on 12/22/15. These residents will be evaluated by the dental provider with their next scheduled visit to the facility.  <u>Systematic Changes</u> Social Services Director will maintain a running list of residents due for an annual evaluation by a dentist. This list is to remain current to ensure facility residents receive a dental evaluation at least annually.  <u>Monitoring</u> During the Quarterly MDS Assessment and Quarterly Care Plan Meeting, Social Services Director is to audit the medical record to ensure each resident has received a dental evaluation within the last year.  Continued	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2016
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 411	<p>Continued</p> <p>failed to ensure four (4) of eighteen (18) sampled residents (Resident #2, Resident #6, Resident #8, and Resident #15) had the opportunity to receive routine dental services. Review of the medical records for Resident #2, Resident #6, Resident #8, and Resident #15, revealed no evidence the residents received an annual evaluation by a Dentist.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Dental Services," dated April 2014, revealed each resident would receive routine dental care as needed, and the findings would be documented in the resident's medical record.</p> <p>1. Review of Resident #2's medical record revealed the facility admitted the resident on 06/22/12, with diagnoses that included Anoxic Brain Injury, and Chronic Systolic Heart Failure. Review of a significant change in condition Minimum Data Set (MDS) assessment dated 09/16/15 revealed no concerns had been identified by the facility related to Resident #2's oral cavity. There was no evidence Resident #2 had received an annual dental evaluation by a dentist since the resident's admission by the facility.</p> <p>Observation of Resident #2 on 12/01/16, at 9:45 AM, revealed the resident was observed to be lying on his/her back in bed and was receiving Isosource 1.5 (liquid nutrition) at 65 milliliters per minute by gastrostomy tube.</p> <p>2. Review of Resident #6's medical record revealed the facility admitted the resident on 10/01/05, with diagnoses that included Mental</p>	F 411	<p>The results of this audit will be presented by the Social Services Director to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then quarterly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	1/15/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  1210312015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(X4) IO 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 411	<p><b>Continued</b></p> <p>Retraction and Seizures. Review of an annual MDS assessment dated 05/13/15, revealed no concerns had been identified by the facility related to Resident #8's oral cavity. There was no evidence Resident #8 had an annual dental evaluation by a dentist since the resident's admission by the facility.</p> <p>Observation of Resident #6 on 12/01/15, at 12:25 PM, revealed the resident was observed in the dining room being fed a pureed diet tray by staff.</p> <p>3. Review of Resident #8's medical record revealed the facility admitted the resident on 10/18/14, with diagnoses that included Alzheimer's and Dementia. Review of an annual MDS dated 08/18/15, revealed the facility had identified no concerns with Resident #8's oral cavity. There was no evidence Resident #8 had received an annual dental exam by a dentist since the resident had been admitted by the facility.</p> <p>Observation of Resident #8 on 12/01/15, at 12:20 PM, revealed the resident was observed to be up in the dining room feeding him/herself a regular no added salt diet tray.</p> <p>4. Review of Resident #15's medical record revealed the facility admitted the resident on 10/27/13, with diagnoses that included Depression and Osteoarthritis. Review of an annual MDS assessment dated 09/09/15, revealed the facility had not identified any concerns with Resident #15's oral cavity. There was no evidence Resident #15 had received an annual dental exam by a dentist since the facility admitted the resident.</p>	F 411			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1R3065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  D. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 411	Continued Observation of Resident #15 on 12/03/15, at 1:00 PM, revealed the resident was observed to be sitting up in a rocking chair watching television.  Interview with the Social Worker on 12/03/15, at 3:55 PM, revealed she was responsible for scheduling dental appointments for residents. The Social Worker stated she had not been aware until recently that residents were required to have an annual dental exam. The Social Worker stated the dentist had only seen residents previously if they had insurance or if they paid privately for the service. The Social Worker stated the dentists were now planning to see all facility residents unless the residents refused.  Interview conducted with the Administrator on 12/03/15, at 4:10PM, revealed it was the responsibility of the Social Worker to ensure residents received routine dental exams.	F 411		
F 441 SS=E	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.	F 411	<u>Corrective Actions for Targeted Residents</u>  No residents have shown ill effects from cited practice. 1:1 and group education was initiated on 12/2/15 by Administrative Nurses and Dietary Manager for Nursing Staff and Dietary Staff regarding Infection Control practices related to tray set-up and covering all food/drinks for meal tray transport.  <u>Identification of Other Residents with Potential to be Affected</u>  Current residents have the potential to be affected by this practice. Properly-fitting lids for cups/glasses were obtained on 12/3/15. Until lids obtained, glasses and cups were covered with plastic wrap by Dietary Staff for transporting meal trays, starting 12/2/15.  <u>Systematic Changes</u>  Observation of meal tray set-up and hallway tray pass will be conducted on a daily basis by Administrative Staff assigned to the Dining Room each day to ensure all food/drinks are covered during meal tray transport. Consultant Registered Dietician will observe the Dining Program at least monthly during her/his compliance visits to ensure all food/drinks are covered for meal tray transport  Continued	

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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:  186085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/03/2016
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		
(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 441	<p>Continued</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to 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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection. On 12/01/15, nursing staff was observed transporting food uncovered in the facility hallways.</p> <p>The findings include:  Review of the facility's policy "Food Transporting," no date, revealed if trays were going to the floor,</p>	F 441	<p>Mandatory In-service was conducted on 12/10/15 by the Executive Director for Dietary and Nursing Staff regarding the need to follow infection Control Practices of covering all food/liquid containers when transporting meal trays. This in-service will be repeated by the ED on 1/14/16 to ensure Dietary and Nursing Staff is educated. Newly-hired Nursing and Dietary Staff will be educated during their orientation period by his/her preceptor regarding the need to follow Infection Control Practices of covering all food/liquid containers when transporting meal trays.</p> <p><u>Monitoring</u></p> <p>Director of Nursing will conduct weekly observation audits of 10% of resident population for meal tray set-up and meal tray transport in the Dining Room and on the hallway to ensure compliance with Infection Control Practices of food/drinks being covered. Results of this audit will be presented by the DON to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then quarterly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	1/15/16	

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

PRINTED: 1211612015  
FORM APPROVED  
OMB NO 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 309 WEST MAPLE AVENUE LANCASTER, KY 40444		
(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)	(X4) COMPLETION DATE	
F 441	<p>Continued</p> <p>all items must be covered unless the tray was transported directly to the resident's room.</p> <p>Observations on 12/01/15 at 12:42 PM during the noon meal service revealed Certified Medication Technician (CMT) #2 was transporting uncovered drinks in the hallway up to 40 feet from the meal cart to resident rooms. The GMT was observed to transport uncovered drinks at least five times during this meal service observation.</p> <p>Interview with CMT #2 on 12/03/15 at 1:25 PM revealed that she should not have transported the drinks down the hall uncovered. The GMT said she did not realize some of them were uncovered and did not know why some glasses were covered and some were not.</p> <p>Interview with the Dietary Manager on 12/03/15 at 2:54 PM revealed she did not know why some of the glasses had lids and some did not, but they were changing supply companies. The Dietary Manager said the facility did not have lids for all cups and glasses.</p> <p>Interview with the Registered Dietitian on 12/02/15 at 3:16 PM revealed CMT #2 should not have been transporting trays with uncovered drinks in the hallways.</p>	F 441			

FORM CMS-2667(02-03) Previous Versions Obsolete

EventID: U18611

Facility ID: 100710

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

PRINTED: 12/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(X4) 10 PREFIX TAG  F 456 SS E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG  F 456	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p><b>493.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</b></p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure that a reach-in refrigerator was in safe operating condition. Observation on 11/30/15 revealed a reach-in refrigerator that was in use that was not in safe operating condition.</p> <p>The Findings include:</p> <p>Interview with the facility Administrator on 11/30/15 at 8:17 PM revealed the facility did not have a policy regarding equipment.</p> <p>Observations revealed a reach-in refrigerator in the kitchen had the following temperatures: 65 degrees Fahrenheit on 11/30/15 at 8:51 PM, 52 degrees F on 11/30/15 at 7:30 PM, 45 degrees F on 12/01/15 at 11:35 AM, 46 degrees F on 12/01/15 at 12:41 PM, and 44 degrees F on 12/02/15 at 8:53 AM.</p> <p>Interview with Cook #1 on 12/01/15 at 12:59 PM revealed that she had not noticed the reach-in cooler not maintaining a safe temperature.</p> <p>Interview with the Maintenance Director on 12/02/15 at 3:40 PM revealed he had not received a work order for the reach-in cooler prior to 11/30/15.</p> <p>Interview on 12/03/15 at 4:07 PM with the Dietary Manager revealed that she was not aware there had been a problem with the reach-in cooler not maintaining a safe temperature. The DM stated the temperature logs had recorded temperatures all within the safe zone.</p>		<p><u>Corrective Actions for Targeted Residents</u></p> <p>No residents have shown ill effects from cited practice. When inappropriate temperature of reach-in cooler was reported, all food was removed from this cooler and disposed of on 11/30/15 by the Dietary Staff. Cooler was serviced each day until proper temperature was maintained. Reach-in cooler was placed back in operation on 12/6/15.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current residents have the potential to be affected by this practice. No ill effects have been noted from facility residents. Dietary Manager was counseled on 12/8/15 by the Executive Director regarding the need to maintain kitchen equipment in safe operating condition.</p> <p><u>Systematic Changes</u></p> <p>Beginning 12/7/15, Dietary Staff was in-serviced by the Dietary Manager on safe cooler temperatures, maintaining daily Temperature Logs, and notification of the Maintenance Director if inappropriate temperatures are observed. This education was ongoing until 12/11/15 to ensure Dietary Staff is educated. Contracted Registered Dietician will check all cooler/freezer temperatures, in addition to the Temperature Log for this equipment, during his/her compliance visits.</p> <p><u>Monitoring</u></p> <p>An audit of cooler/freezer temperatures, as well as appropriate temperatures documented on the daily Temperature Logs, will be conducted by the Dietary Manager weekly to ensure compliance of equipment is being maintained in safe operating condition.</p> <p style="text-align: right;">Continued</p>	

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

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OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2016
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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 456	Continued	F 456	Results of this audit will be presented by the DM to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% is met for 4 consecutive weeks; then monthly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	1/15/16

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185065	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 1/15/2016	Y3
NAME OF FACILITY CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix <u>F0242</u>	Correction	ID Prefix <u>F0248</u>	Correction	ID Prefix <u>F0278</u>	Correction
Reg. # <u>483.15(b)</u>	Completed	Reg. # <u>483.15(f)(1)</u>	Completed	Reg. # <u>483.20(g) - (i)</u>	Completed
LSC _____	01/15/2016	LSC _____	01/15/2016	LSC _____	01/15/2016
ID Prefix <u>F0279</u>	Correction	ID Prefix <u>F0282</u>	Correction	ID Prefix <u>F0312</u>	Correction
Reg. # <u>483.20(d), 483.20(k)(1)</u>	Completed	Reg. # <u>483.20(k)(3)(II)</u>	Completed	Reg. # <u>483.25(a)(3)</u>	Completed
LSC _____	01/15/2016	LSC _____	01/15/2016	LSC _____	01/15/2016
ID Prefix <u>F0323</u>	Correction	ID Prefix <u>F0371</u>	Correction	ID Prefix <u>F0411</u>	Correction
Reg. # <u>483.25(h)</u>	Completed	Reg. # <u>483.35(l)</u>	Completed	Reg. # <u>483.55(a)</u>	Completed
LSC _____	01/15/2016	LSC _____	01/15/2016	LSC _____	01/15/2016
ID Prefix <u>F0441</u>	Correction	ID Prefix <u>F0456</u>	Correction	ID Prefix _____	Correction
Reg. # <u>483.65</u>	Completed	Reg. # <u>483.70(c)(2)</u>	Completed	Reg. # _____	Completed
LSC _____	01/15/2016	LSC _____	01/15/2016	LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <u>ad</u>	DATE <u>01/21/16</u>	SIGNATURE OF SURVEYOR <u>Alicia Dunn</u>	DATE <u>01/21/16</u>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/3/2015

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES  NO

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 100719	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 1/15/2016	Y3
NAME OF FACILITY CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444		

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix N0114	Correction	ID Prefix N0125	Correction	ID Prefix N0144	Correction
Reg. # 902 KAR 20:300-6(2)(a)	Completed	Reg. # 902 KAR 20:300-6(5)(a)	Completed	Reg. # 902 KAR 20:300-6(7)(b)2.a.	Completed
LSC	01/15/2016	LSC	01/15/2016	LSC	01/15/2016
ID Prefix N0185	Correction	ID Prefix N0187	Correction	ID Prefix N0194	Correction
Reg. # 902 KAR 20:300-7(2)(e)	Completed	Reg. # 902 KAR 20:300-7(3)(a)	Completed	Reg. # 902 KAR 20:300-7(4)(c)2.	Completed
LSC	01/15/2016	LSC	01/15/2016	LSC	01/15/2016
ID Prefix N0207	Correction	ID Prefix N0220	Correction	ID Prefix N0283	Correction
Reg. # 902 KAR 20:300-8(1)(c)	Completed	Reg. # 902 KAR 20:300-8(7)(b)	Completed	Reg. # 902 KAR 20:300-10(8)(b)	Completed
LSC	01/15/2016	LSC	01/15/2016	LSC	01/15/2016
ID Prefix N0303	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 902 KAR 20:300-13(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/15/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

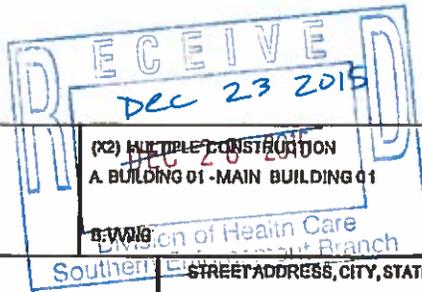
REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>ad</i>	DATE <i>01/21/16</i>	SIGNATURE OF SURVEYOR <i>Alisia Dunn</i>	DATE <i>01/21/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/3/2015

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES  NO

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

PRINTED: 12/18/2015  
FORM APPROVED  
OMB NO 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  12/03/2015
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1966</p> <p>SURVEY UNDER: 2000 existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 1 (332)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel generator</p> <p>A life safety code survey was initiated and concluded on 12/03/15, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to not be in compliance with NFPA 101 Life Safety Code, 2000 Edition. The facility is licensed for ninety-six (96) residents, with a census of ninety-one (91) residents on the day of the survey.</p> <p>Deficiencies were identified during this survey at "D" level.</p>	K 000	<p>Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Lancaster of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Lancaster files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.</p>	
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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

TITLE

*[Handwritten Signature]*

*Executive Director*

*12/23/15*

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.

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

PRINTED: 12/10/2015  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01-MAIN BUILDING 01  R. WING	(X3) DATE SURVEY COMPLETED  12/03/2015
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 12/03/15 at 11:38 AM with the Maintenance Director revealed two locking devices on the two doors leading into the Kitchen. Further observation revealed two of the locking devices were located 60 inches above the floor. Interview with the Maintenance Director at the time of observation revealed he was told the locks needed to be on the doors to prevent residents from entering the kitchen area.</p> <p>Observation on 12/03/15 at 11:48 AM with the Maintenance Director revealed a lock mounted at a height of 60 inches on a storage room door in the service area. Interview with the Maintenance Director at the time of observation revealed he was not aware the lock could not be mounted greater than 48 inches from the floor.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K038	<p><u>Corrective Action for Targeted Area</u></p> <p>On 12-7-15 the Maintenance Director removed the secondary locking device on the two doors leading into the kitchen. With the removal of the secondary locks on the kitchen doors there was no longer a lock located above 48 inches from the floor on the doors leading to the kitchen doors. On 12-7-15 the Maintenance Director relocated the lock on the storage room door in the service area at a height no greater than 48 inches from the floor.</p> <p><u>Identification of Area with Potential to be affected</u></p> <p>On 12-4-15 the Maintenance Director inspected facility doors for compliance with latches being no higher than 48 inches from the floor and needed repairs were made and completed on 12-28-15 by the Maintenance Director.</p> <p><u>Systematic Changes</u></p> <p>Measures to ensure compliance include a quarterly audit conducted by the Maintenance Director of the facility door lock placement for compliance with NFPA 101.</p> <p><u>Monitoring</u></p> <p>Results of these audits will be reported quarterly by the Maintenance Director for one year to the Quality Assurance Performance Improvement Committee for Review and Recommendations. The Executive Director and Maintenance Director will follow up on recommendations from the QAPI Committee to assure compliance.</p>	

Continued

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

PRINTED: 12/18/2015  
FORM APPROVED  
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER		STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(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)  COMPLETION DATE
K 038 Continued	<p>7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 1:*Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor.</p> <p>Exception No.2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.</p>	K038	<p>The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p> <p>1/5/16</p>

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 -MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444	
(X4) JD PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(O) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single Lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8., 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observallon and interview it was determined the facility failed to ensure illumination of emergency exits was according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, twenty-six (26) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 12/03/15 at 12:32 PM with the Maintenance Director revealed the exterior exits at the Chapel and Short Hall were not equipped with a two-bulb light fixture illuminating the exit egress. Interview with the Maintenance Director at the time of observation revealed he was not aware the light fixtures at the emergency exits needed to be equipped with two light bulbs.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>7.8.1.4• Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p>	K045	<p><u>Corrective Action for Targeted Area</u></p> <p>On 12-16-15 the Maintenance Director replaced the exterior lights at the Chapel and Short Hall exits, with a 2 bulb light fixture.</p> <p><u>Identification of Area with Potential to be affected</u></p> <p>On 12-4-15 the Maintenance Director inspected exterior egress lighting and found no other areas affected.</p> <p><u>Systematic Changes</u></p> <p>Measures to ensure compliance include a monthly audit conducted by the Maintenance Director of egress lighting illumination and compliance with NFPA 101.</p> <p><u>Monitoring</u></p> <p>Results of these audits will be reported monthly by the Maintenance Director to the Quality Assurance Performance Improvement Committee for Review and Recommendations. The Executive Director and Maintenance Director will follow up on recommendations from the QAPI Committee to assure compliance. The QAPI Committee consists of the Executive Director, Medical Director, Consultant Pharmacist, Director of Nursing, Assistant Director of Nursing, MDS Nurse Coordinator, Social Services Director, Activities Director, Dietary Manager, Maintenance Director, Housekeeping / Laundry Director, Business Office Manager, Admissions Director, and Therapy Manager.</p>	1/5/16