

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

PRINTED: 01/30/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2011
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An annual survey and abbreviated survey (KY #16676, KY #16682 and KY #17215) was conducted on 12/14/11 through 12/16/11, and a Life Safety Code survey was conducted on 12/15/11 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "F". KY #16682 was substantiated with deficiencies cited. KY #16676 and KY #17215 were unsubstantiated with no deficiencies cited.	F 000	<u>Disclaimer for Plan of Correction</u> Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Kuttawa of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Kuttawa 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cindy Minton* TITLE: *Adm* (X6) DATE: *1.20.12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42065	
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F 157	<p>Continued From page 1</p> <p>resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to inform the physician of a need to alter treatment significantly for one resident (#2), in the selected sample of fourteen. Resident #2 had a physician's order for a wound vac due to two stage four pressure ulcers. The wound vac was not functioning on 12/13/11, and another treatment was initiated. The physician was not notified until 12/15/11.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure "Notification of Physician," revised 09/08, revealed the nurse would notify the resident's attending physician when there was a need to alter the resident's treatment significantly.</p> <p>A record review revealed Resident #2 was re-admitted to the facility on 10/14/11 with diagnoses to include Paraplegia, Paralytic Syndrome, Osteomyelitis and Diabetes. A review of the annual Minimum Data Set (MDS), dated 10/28/11, revealed the facility identified the resident to be cognitively intact and required extensive assistance with bed mobility and</p>	F 157	<p>F 157</p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Residents</u></p> <p>On 12/15/11, the attending physician for Resident #2 was notified of a need to alter the treatment. Orders were received for a new wound care treatment. The care plan was updated to reflect these changes.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current residents with wound care treatment orders have the potential to be affected. Charts were reviewed on 1/6/12 by the Assistant Director of Nursing. No other residents were affected.</p> <p><u>Systematic Changes</u></p> <p>Licensed staff will be educated by the Director of Nursing on 1/13/12 regarding notification of physician with</p>	

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F 157	<p>Continued From page 2 transfers.</p> <p>A review of the physician's admission orders, dated 10/14/11, revealed "to apply the wound vac at 120 cubic centimeters (cm) continuous suction to the right and left gluteal fold wounds." The physician's order specified to change the wound vac every Sunday, Tuesday, and Thursday.</p> <p>A review of the "Wound Evaluation Flow Sheet," dated 12/13/11, revealed a wet to moist dressing was used for the right and left gluteal wounds, instead of the wound vac. There was no evidence of physician's order, on 12/13/11, to change the treatment from the wound vac to the wet to moist dressing.</p> <p>An observation, on 12/14/11 at 2:30 PM, revealed the resident's wound vac was not functioning. An interview with Resident #2 revealed the wound vac had not worked "in over a week." The resident refused a skin assessment on 12/15/11.</p> <p>An interview with Registered Nurse (RN) #2, on 12/15/11 at 10:50 AM, and on 12/16/11 at 1:20 PM, revealed he completed the wet to moist treatment for Resident #2, on 12/13/11. He revealed it was reported to him the wound vac was not functioning, and he stated that he thought the physician was already notified. RN #2 stated that he completed a wet to moist dressing because it would be better than no treatment; however, he revealed the physician was not notified.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 12/16/11 at 2:00 PM and at 3:00 PM, revealed he reported to LPN #4, on 12/14/11, that</p>	F 157	<p>any resident change of status. The Assistant Director of Nursing will monitor new treatment orders and 24-hour report sheets daily to ensure charge nurses are notifying the MD with changes in a resident's condition in a timely manner.</p> <p><u>Monitoring</u></p> <p>The Assistant Director of Nursing will conduct a monthly audit of wound care treatment orders and MD notification. The audit will ensure that wound care treatment orders match the current wound care treatment that the resident is receiving and that the physician has been notified of current treatment orders. The Assistant Director of Nursing will report these findings to the Performance Improvement Committee for three months for review and recommendations. The Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.</p>	1/29/12

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F 157	Continued From page 3 the wound vac was not functioning. He stated that he thought the physician was notified of the wet to moist dressing, as it was intact on 12/14/11. As soon as he was aware the order was not received, on 12/15/11, the physician was notified. He revealed the physician should be made aware of any treatment change. An interview with the Acting Director of Nursing (DON), on 12/16/11 at 4:00 PM, revealed she expected the staff to notify the physician if the current treatment could not be provided. She revealed the physician should be notified of any treatment change. An interview with Medical Doctor (MD) #1, on 12/16/11 at 12:40 PM, revealed he was not notified of the non-functioning wound vac on 12/13/11. He revealed he expected the staff to notify him of any treatment change.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services provided met professional standards of quality for one resident (#2), in the selected sample of fourteen, related to not following physician's orders. Findings include:	F 281	F 281 Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

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F 281	<p>Continued From page 4</p> <p>A review of the facility's policy/procedure, "Physician's Orders," dated 12/08, revealed "all treatments administered to a resident must be ordered by the attending physician. Therapy or any treatment could not be administered to a resident without written approval from the attending physician."</p> <p>A record review revealed Resident #2 was re-admitted to the facility on 10/14/11 with diagnoses to include Paraplegia, Paralytic Syndromes, Osteomyelitis and Diabetes. A review of the Annual Minimum Data Set (MDS), dated 10/28/11, revealed the facility identified the resident to be cognitively intact and required extensive assistance with bed mobility and transfers.</p> <p>A review of the physician's admission orders, dated 10/14/11, revealed "to apply the wound vac at 120 cubic centimeters (cm) continuous suction to the right and left gluteal fold wounds." The physician's order specified to change the wound vac every Sunday, Tuesday, and Thursday.</p> <p>A review of the "Wound Evaluation Flow Sheet," dated 12/13/11, revealed a wet to moist dressing was used for the right and left gluteal wounds, instead of the wound vac. There was no evidence of a physician's order, on 12/13/11, to change the treatment from the wound vac to the wet to moist dressing.</p> <p>An observation, on 12/14/11 at 2:30 PM, revealed the resident's wound vac was not functioning. An interview with Resident #2 revealed the wound vac had not worked "in over a week."</p>	F 281	<p><u>Corrective Actions for Targeted Residents</u></p> <p>On 12/15/11, the attending physician for Resident #2 was notified of a need to alter the treatment. Orders were received for a new wound care treatment. The care plan was updated to reflect these changes.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current residents with wound care treatment orders have the potential to be affected. Charts were reviewed on 1/6/12 by the Assistant Director of Nursing. No other residents were affected.</p> <p><u>Systematic Changes</u></p> <p>Licensed staff will be educated by the Director of Nursing on 1/13/12 regarding notification of physician with any resident change of status. The Assistant Director of Nursing will monitor new treatment orders and 24-hour report sheets daily to ensure charge nurses are notifying the MD with changes in a resident's condition in a timely manner.</p>		

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F 281	Continued From page 5 An interview with Registered Nurse (RN) #2, on 12/15/11 at 10:50 AM, and on 12/16/11 at 1:20 PM, revealed he completed the wet to moist treatment for Resident #2, on 12/13/11. He revealed it was reported to him the wound vac was not functioning. He revealed he completed a wet to moist dressing because it would be better than no treatment; however, he did not notify the physician of the treatment change. An interview with Licensed Practical Nurse (LPN) #2, on 12/16/11 at 2:00 PM and at 3:00 PM, revealed he thought the physician was notified of the wet to moist dressing, as it was intact on 12/14/11. As soon as he was aware the order was not received, on 12/16/11, the physician was notified. He revealed the physician should be made aware of any treatment changes. An interview with the Acting Director of Nursing (DON), on 12/16/11 at 4:00 PM, revealed she expected the staff to notify the physician if the current treatment could not be provided, so new orders could be obtained. An interview with Medical Doctor (MD) #1, on 12/16/11 at 12:40 PM, revealed he expected the staff to notify him of any treatment changes.	F 281	<u>Monitoring</u> The Assistant Director of Nursing will conduct a monthly audit of wound care treatment orders and MD notification. The audit will ensure that wound care treatment orders match the current wound care treatment that the resident is receiving and that the physician has been notified of current treatment orders. The Assistant Director of Nursing will report these findings to the Performance Improvement Committee for three months for review and recommendations. The Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.	1/29/12	
F 315 SS=D	483.26(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	F 315 Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility		

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F 315	<p>Continued From page 6</p> <p>who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedures, it was determined the facility failed to provide appropriate treatment and services related to incontinent care for one resident (#7), in the selected sample of fourteen.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Perineal Care," dated November 1988 and updated in June of 2002 and September of 2008, revealed the staff members were to position the resident to bend their knees slightly and to spread the legs, if possible. The staff member was to separate the labia with one hand and wash with the other hand, using gentle downward strokes, from the front to the back of the perineum. If rinsing was necessary, the staff member was to use a clean wash cloth and rinse thoroughly from front to back and pat the area dry. The resident was to be placed on their side in a Sim's Position, if possible, to expose the anal area and clean, rinse and dry the anal area, starting at the posterior vaginal opening and wiping front to back.</p> <p>A review of the facility's policy/procedure "Catheter Care," effective January 1999, revealed the staff members were to clean the catheter</p>	F 316	<p>Is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Residents</u></p> <p>Resident #7 is currently receiving catheter care per facility policy. Care plan has been revised to reflect these changes.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Current residents in the facility that require catheter care have the potential to be affected.</p> <p><u>Systematic Changes</u></p> <p>Current Certified Nursing Assistants will be in-serviced on catheter care by the Assistant Director of Nursing, to be completed on 1/13/12. A competency on catheter care will be performed upon hire and annually thereafter.</p> <p><u>Monitoring</u></p> <p>The Director of Nursing will review 10% of Certified Nursing Assistants performing catheter care monthly times three to ensure proper catheter care is being performed. The Director of Nursing will report these findings to the Performance Improvement Committee</p>	
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F 316	<p>Continued From page 7</p> <p>beginning at the meatus, then downward toward the drainage connection, at least once daily with soap and water and more often if soiled.</p> <p>A record review revealed Resident #7 was admitted to the facility on 11/24/11 with diagnoses to include Fracture of the Right Femur Neck in the leg and the Right Radius and Ulnar Bones in the arm, and Chronic Kidney Disease. A review of the admission assessment, dated 11/24/11, revealed the facility identified Resident #7 to be incontinent of bowel and had an indwelling urinary catheter, which was to be removed "when the resident was medically stable."</p> <p>A review of the care plan for incontinence, dated 12/01/11, revealed the resident required the extensive assistance of two staff members for incontinent care, and interventions included to check and change the briefs during rounds and as needed. A review of the Certified Nurse Aide (CNA) care plan revealed the resident was to be provided perineal cleansing with the assistance of two staff members.</p> <p>An observation, during the provision of incontinent care for Resident #7, on 12/15/11 at 3:15 PM, revealed the resident was incontinent of loose stool. CNA #6 attempted to remove the loose stool, in the vaginal area, utilizing the same area of the washcloth, using a back and forth wiping motion. CNA #6 stated the way the resident was lying made it hard to adequately clean the perineal region. The CNA proceeded to wipe up and down the resident's catheter tubing without changing the washcloth. Afterwards, the CNA went to get assistance from another CNA to reposition the resident. The rectal area was</p>	F 316	<p>for review and recommendations. The Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.</p>	1/29/12

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F 315	Continued From page 8 noted with loose stool and was cleaned with a back and forth motion, using the same washcloth, which contaminated the clean area. An interview with CNA #6, at the time of the observation, revealed he was trained to provide Incontinent care and to fold the washcloth and to avoid using a contaminated surface, but "was just nervous." An interview with Licensed Practical Nurse (LPN) #6, on 12/16/11 at 2:46 PM, revealed the CNAs were trained in the proper technique, which was "to wash down from the meatus, down from the tube and to be sure they don't contaminate the area," and she stated "I always expect them to clean front to back." An interview with the Director of Nursing (DON), on 12/16/11 at 3:50 PM, revealed if stool was found in the vaginal area, the staff members were expected to clean from front to back. The staff members were trained about proper Incontinent care upon hire, with monthly training and yearly evaluations and competency training.	F 315		
F 323 SS=D	483.25(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.	F 323	F 323 Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

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F 323	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received adequate assistance devices to prevent accidents for two residents (#2 and #4), in the selected sample of fourteen. Resident #2 sustained a fall from a lateral rotation air mattress, and was placed back on the same air mattress without a nursing assessment. Resident #4 was observed in his/her bed without fall interventions in place.</p> <p>Findings include:</p> <p>A review of the "Fall Prevention Program", revised 07/09, revealed the objective of the program included the systematic assessment of fall risk factors. The protocol for all residents included an assessment of assistive devices for proper fit and use. Potential interventions for fall prevention included bed alarms and mats placed on the floor at bedside.</p> <p>1. A record review revealed Resident #2 was admitted to the facility on 12/23/10, with a readmission date on 10/14/11. Diagnoses included Paraplegia, Paralytic Syndrome and Osteomyelitis. A review of the annual Minimum Data Set (MDS), dated 10/28/11, revealed the facility identified the resident to be cognitively intact and required extensive assistance with bed mobility and transfers.</p> <p>A review of the "Resident Care Kardex," undated, revealed an air flow mattress was added to the resident's bed on 02/26/11.</p>	F 323	<p><u>Corrective Actions for Targeted Residents</u></p> <p>Resident #2 was assessed by the Director of Nursing for the safe use of an air mattress per facility policy on 12/15/11. Resident #4 currently has the bed alarm and fall mat in place and functional.</p> <p><u>Identification of Other Residents with the Potential to be Affected</u></p> <p>Current residents requiring use of air mattresses and assistive devices have the potential to be affected. Residents requiring use of air mattresses were assessed by the Director of Nursing/Assistant Director of Nursing on 12/15/11.</p> <p><u>Systematic Changes</u></p> <p>The facility implemented an Air Mattress Assessment and Policy. Upon recommendation of use of an air mattress, an assessment will be completed by a Licensed Nurse prior to placement. Residents placed on air mattresses will then be assessed quarterly and with any significant change in the resident's condition to ensure safe use. Licensed Nurses were educated on the new Air Mattress Assessment and Policy on 1/13/12.</p>	
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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: 186318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055		
(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 From page 10</p> <p>A review of the interdisciplinary progress notes, dated 04/04/11 at 11:00 PM, revealed the resident sustained a fall from the bed while repositioning himself/herself. Further review revealed the resident was placed back in the bed after the fall. There was no documented evidence of an assessment for the safe use of the air mattress prior to, or after the resident's fall.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 12/16/11 at 2:00 PM, revealed he was the nurse on duty on 04/04/11. He revealed Resident #2 sustained a fall from the air mattress after attempting to reposition himself/herself in the bed; however the fall was unwitnessed. He revealed there was no documented assessment completed after the resident's fall. No further explanation was provided.</p> <p>An observation of the air mattress, on 12/14/11 at 9:45 AM, revealed it was a "Pressure Guard" air mattress, with the setting on low pressure. Resident #2 was observed to be lying on the air mattress on 12/14/11 at 2:30 PM, and on 12/15/11 at 9:45 AM and 10:35 AM.</p> <p>An interview with the Acting Director of Nursing (DON), on 12/16/11 at 2:30 PM, revealed she was unable to provide documentation of an assessment for the safe use of the air mattress for Resident #2.</p> <p>2. A record review revealed Resident #4 was admitted to the facility on 12/12/07 with diagnoses to include Hypertension, Anxiety and Peripheral Neuropathy.</p>	F 323	<p><u>Monitoring</u></p> <p>The Director of Nursing will monitor the assessments of residents on air mattresses monthly times three months. The Director of Nursing will monitor 10% of assistive devices for proper placement and functioning monthly times three. The Director of Nursing will report these findings to the Performance Improvement Committee for review and recommendations. This committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.</p>	1/29/12	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
(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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 11</p> <p>A review of the "Resident Care Kardex," undated, revealed a pressure alarm was added to the resident's bed on 12/03/10, due to the resident being identified as a falls risk. A review of the physician's orders, dated 03/07/11, revealed "a floor mat to the resident's bedside for safety."</p> <p>A review of the quarterly MDS, dated 11/03/11, revealed the facility identified the resident to be moderately cognitively impaired and required limited assistance with transfers. A review of the "Fall Risk Evaluation," dated 11/03/11, revealed the resident was at risk for falls.</p> <p>Observations, on 12/14/11 at 9:45 AM, 2:40 PM, 3:20 PM and 3:50 PM, revealed Resident #4 was in bed with the sensor alarm disconnected to the bed. The fall mat to the right side of the resident's bed was pushed completely under the bed.</p> <p>An interview with Certified Nurse Aide (CNA) #4 and CNA #5, on 12/15/11 at 10:05 AM and 10:15 AM, respectively, revealed they were responsible for the resident's care on 12/14/11 from 8:00 AM to 2:00 PM. They revealed it was their responsibility to ensure the resident's bed alarm and fall mat were in place during their shift.</p> <p>An interview with CNA #1, on 12/14/11 at 5:30 PM, revealed she was responsible for Resident #4's care during the hours of 2:00 PM to 10:00 PM. She revealed the resident's alarm and fall mat placement should be checked every time she went into the resident's room. She stated "I just did not pay attention."</p> <p>An interview with CNA #2, on 12/14/11 at 5:40 PM, revealed she was also responsible for the</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055
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F 323 Continued From page 12
resident's care during the hours of 2:00 PM to 10:00 PM. She revealed she should have ensured the resident's alarm and floor mat was in place at the beginning of the shift.

An interview with Registered Nurse (RN) #2, on 12/14/11 at 5:30 PM, revealed the resident's sensor bed alarm was disconnected and the fall mat was pushed under the bed. She revealed it was the CNAs responsibility to ensure the alarms and mats were in place at shift change.

F 323

An interview with the Acting DON, on 12/16/11 at 4:00 PM, revealed the CNAs were responsible to ensure alarms and mats were in place and functioning for each resident.

F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=D PALATABLE/PREFER TEMP

F 364

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

F 364
Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure residents received food prepared in a manner which retained food quality, taste and appearance. Observations revealed pureed meals were not served in divided plates and had a runny consistency. A review of the Census and Condition Report, dated 12/14/11, revealed the facility census was 62, with four (4) of those

Corrective Actions for Targeted Residents

Resident #17 is receiving pureed foods that are the appropriate consistency.

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
(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 364	<p>Continued From page 13 residents served pureed diets from the kitchen.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Mechanically Altered Diets and Thickened Liquids" and "Pureed Vegetables" and "Pureed Sausage," undated, revealed "pureed items should be served individually on a plate and not all blended together, unless the diet order is prescribed in that manner. When bread is blended into the meal, a recipe should be followed so proportions are appropriate. The volume of the liquid required may vary slightly, depending on the texture of the (vegetable or meat) product. The amount of the thickener will vary slightly. Start with a half tablespoon and add gradually. The consistency must be a mashed potato consistency."</p> <p>A record review revealed Resident #17 was admitted to the facility on 04/19/10 with a diagnoses of Arteriosclerotic Cardiac Disease and Anemia. A review of the physician's orders, dated 12/09/11, revealed to "downgrade the diet to pureed due to difficulty chewing."</p> <p>An observation of the lunch meal, on 12/14/11 at 12:15 PM, revealed Resident #17 received pureed green beans, mashed potatoes and meat. The portions were not separated. The consistency of the foods were runny and ran into the other foods on the plate. An observation of the supper meal, on 12/14/11 at 6:08 PM, revealed the resident received pureed beef stew and bread sticks, which were a thicker consistency than the noon meal.</p>	F 364	<p><u>Identification of Other Residents with the Potential to be Affected</u></p> <p>Current residents receiving a pureed diet have the potential to be affected.</p> <p><u>Systematic Changes</u></p> <p>Dietary staff will be in-serviced by the Dietary Manager and the Registered Dietician on the appropriate consistency of pureed foods on 1/13/12.</p> <p><u>Monitoring</u></p> <p>The Dietary Manager will monitor the pureed food consistency three times a week times four weeks, then monthly for three months. The Registered Dietician will monitor pureed food consistency two times a month for three months. The Dietary Manager will report these findings to the Performance Improvement Committee for review and recommendations. This committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.</p>	1/29/12

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055		
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F 364	<p>Continued From page 14</p> <p>An interview with the Dietary Manager, on 12/16/11 at 9:00 AM, revealed in order to follow the instructions for a pureed consistency diet, the recipe stated the amount of the food item and the amount of the liquid, but the thickener was estimated as one to two tablespoons. "Most recipes don't say exactly how much thickener." As for the difference in the consistency of the two meals, the Dietary Manager stated there were two different cooks for lunch and supper.</p> <p>An interview with the Registered Dietician, on 12/16/11 at 10:55 AM, revealed the facility recently made a change to a new menu and recipes and currently the staff members were still getting used to the changes.</p>	F 364			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42065
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1956, 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 1991. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/14/11. Christian Care Center of Kuttawa was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for eighty (80) beds and the census was fifty three (53) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p><u>Disclaimer for Plan of Correction</u></p> <p>Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Kuttawa of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Kuttawa 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>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Andy Britton* TITLE: *Adm* (X5) DATE: *1-20-12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055		
(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 000	Continued From page 1	K 000	K 025		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at " F " level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for eighty (80) beds with a census of fifty three (53) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/14/11 between 4:00 PM and 5:00 PM, with the Maintenance Director revealed the smoke partitions extending above the ceiling in the 100, 200, 300, 400, and 500 Hall smoke</p>	K 025	<p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Area</u></p> <p>On 1/7/12, Maintenance Director sealed penetrations with a fire caulk that would resist the passage of smoke and with ratings equal the partition.</p> <p><u>Identification of Areas with Potential to be Affected</u></p> <p>The Maintenance Director inspected smoke barrier walls on 1/7/12 and determined that no other penetrations in the smoke barrier existed.</p> <p><u>Systematic Changes</u></p> <p>The facility will require any internal or external contractor/laborer to advise the Maintenance Director or Administrator prior to working on any smoke barrier wall and will be required to seal penetrations. Any work performed on the smoke barrier walls will be logged by the Maintenance</p>		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42056		
(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 025	Continued From page 2 barriers to be penetrated by pipes and wires The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Interview, on 12/14/11 between 4:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware of the penetrations. This is a repeat deficiency. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	Director on the day the work begins and ensure that all penetrations are filled as work proceeds with fire caulk that meets ASTM E-814, UL 1479 and CAN/ULC S115 and has an equal or greater fire rating of the wall. Maintenance Director and external contractors/ laborers are required to seal penetrations using fire resistant products that have an equal or greater fire rating of the wall. <u>Monitoring</u> Findings of quarterly smoke wall inspections will be reported by the Maintenance Director to the Performance Improvement Committee for review and recommendations. Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist. Recommendations to be followed up by the facility's Maintenance Director and Administrator to assure compliance.	1/29/12	
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050			

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K 050 SS=F	<p>Continued From page 3</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for eighty (80) beds with a census of fifty three (53) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 12/14/11 at 11:00 AM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. Fire drills were being conducted as follows:</p> <p>First Shift 11/07/11 @ 10:45 AM 10/24/11 @ 9:05 AM 9/14/11 @ 12:30 PM 8/24/11 @ 10:00 AM</p>	K 050	<p>K 050</p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Area</u></p> <p>The Maintenance Director was in-serviced by the Administrator on 1/6/12 to insure that fire drills are conducted at unexpected times and under varying conditions, at least once quarterly on each shift.</p> <p><u>Identification of Areas with Potential to be Affected</u></p> <p>Staff will be in-serviced on 1/13/12 by the Maintenance Director and Administrator on proper time variances for conducting fire drills.</p> <p><u>Systematic Changes</u></p> <p>Staff will be in-serviced by the Maintenance Director on hire and annually. Fire drills will continue to be conducted at least one per quarter per shift at unexpected times.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055		
(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 050	Continued From page 4 7/11/11 @ 10:30 AM 5/29/11 @ 9:30 AM 5/28/11 @ 10:00 AM Second Shift 11/08/11 @ 2:45 PM 9/23/11 @ 3:15 PM 8/10/11 @ 2:27 PM 7/05/11 @ 8:30 PM 6/30/11 @ 7:00 PM 5/14/11 @ 6:00 PM Thrd Shift 11/10/11 @ 1:30 AM 10/10/11 @ 11:45 PM 9/26/11 @ 12:00 AM 8/31/11 @ 1:20 AM 7/12/11 @ 11:30 PM 6/20/11 @ 12:00 AM 5/13/11 @ 12:30 AM Interview, on 12/14/11 at 11:00 AM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under veried condilions on all shifts.	K 050	<u>Monitoring</u> Maintenance Director and Adminstrator will monitor the system for compliance. The Maintenance Director will report findings quarterly to the Performance Improvement Committee for review and determination of ongoing compliance. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.	1/29/12	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in eordcance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all porlons of the	K 056	Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:		

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K 056	<p>Continued From page 5</p> <p>building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty (80) beds with a census of fifty three (53) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/14/11 at 4:24 PM, with the Maintenance Director revealed one (1) attic space open to the outside, located above the 300 Hall area door to the courtyard. The added roof and attic space was made of combustible materials, and was not sprinkler protected.</p> <p>Interview, on 12/14/11 at 4:24 PM, with the Maintenance Director revealed the roof was built by the previous owner to shed water away from</p>	K 056	<p><u>Corrective Actions for Targeted Area</u></p> <p>The cited attic area had a sprinkler head added to the space on 12/29/11 by the facility's contracted sprinkler company.</p> <p><u>Identification of Areas with Potential to be Affected</u></p> <p>During walk-thru, the Maintenance Director also identified four areas with overhangs that potentially needed to be sprinklered. These areas were addressed with a new sprinkler head installed on 12/29/11 by the facility's contracted sprinkler company.</p> <p><u>Systematic Changes</u></p> <p>The Maintenance Director will consult with contracted sprinkler company during their quarterly inspection on the proper placement of sprinkler head coverage and will record findings in a Quality Assurance study.</p> <p><u>Monitoring</u></p> <p>The Maintenance Director will report his findings of the Quality Assurance study to the Performance Improvement Committee on quarterly basis for review and determination of ongoing</p>	

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K 056	Continued From page 6 the outside door leading the courtyard. Reference: NFPA 13 (1999 Edition) 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	compliance. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.	1/29/12	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty (80) beds with a census of fifty three (53) on the day of the survey. The findings include: Observation, on 12/14/11 between 1:00 PM and 4:00 PM, with the Maintenance Director revealed linen carts, and lifts were being stored in the 100, and 200 corridors.	K 072	K 072 Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Area</u> On 100 hall, linen carts and lifts were temporarily placed in a vacant room (112) on 12/14/11. On 200 hall, lifts and linen carts were placed in clean linen storage on 12/14/11. Linen carts will be stored in the clean linen closets when not in use, effective 1/20/12. Lifts will be stored in storage room 113 and 400 hall linen storage when not in use, effective 1/20/12. The two vending machines were moved		

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K 072	Continued From page 7 Interview, on 12/14/11 between 1:00 PM and 4:00 PM, with the Maintenance Director revealed the facility routinely stored linen carts, and lifts in the corridors. Observation, on 12/14/11 at 3:20 PM, with the Maintenance Director revealed two (2) vending machines placed in the path of egress located in the 300 Hall area. Interview, on 12/14/11 at 3:20 PM, with the Maintenance Director revealed they had just moved the machines to make more room in the 300 Hall area for residents to gather. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	from 300 hall to the employee break room on 12/15/11. The vending machines will be kept in the employee break room. <u>Identification of Areas with Potential to be Affected</u> The building was inspected on 12/15/11 by the Maintenance Director and did not find any other items stored in the path of egress. <u>Systematic Changes</u> Staff will be in-serviced on 1/13/12 by the Maintenance Director and Administrator to continue to ensure that no items are stored in the hallways. <u>Monitoring</u>		
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria	K 074	The Director of Maintenance/Weekend Manager will visually check halls daily to insure that passageways are clear from obstructions and that items are not stored in hallways. Any found obstructions will be removed immediately. The Weekend Manager will turn in a daily audit report to the Maintenance Director, and the results of both reports will be presented by the Maintenance Director to the Performance Improvement Committee for review and recommendations. This committee consists of the		

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K 074	<p>Continued From page 8</p> <p>specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4, 19.7.5.3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for eighty (80) beds and the census was fifty three (53) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/14/11 at 4:00 PM, with the Maintenance Director revealed the privacy curtains within the Shower Room located in the 500 Hall, were of a solid fabric hung directly below the ceiling. The solid fabric would obstruct the spray pattern of the automatic sprinklers in the event of a fire.</p> <p>Interview, on 12/14/11 at 4:00 PM, with the Maintenance Director revealed they were aware of the requirements for proper operations of the sprinkler system. He also acknowledged that the solid fabric curtains were overlooked and could obstruct the spray pattern in the event of a fire.</p> <p>This is a repeat deficiency.</p>	K 074	<p>Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.</p> <p>K 074</p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Target Area</u></p> <p>The shower curtains in 500 hall shower rooms were lowered 18" from the ceiling on 1/6/12, and new shower curtains with 1/2" mesh at the top of the curtains were ordered on 12/15/11 and will be installed upon arrival.</p> <p><u>Identification of Areas with Potential to be Affected</u></p> <p>On 12/15/11, the Maintenance Director walked through the entire facility and found that no other areas were affected.</p>	1/29/12

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K 147	<p>Continued From page 10 residents, staff, and visitors. The facility is licensed for eighty (80) beds with a census of fifty three (53) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 12/14/11 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) A room heating unit plugged into an extension cord located in room #333. 2) Multiple extension cords plugged together outside across the front of the facility, for holiday decorations. The extension cords were not rated to be outside, and not plugged into a ground fault receptacle. <p>Interview, on 12/14/11 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed he was not aware the extension cord to the heating unit was prohibited. He also stated that the reason for the multiple extension cords outside was due to the outside plugs located closer to the front door not working.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet</p>	K 147	<p><u>Corrective Actions for Targeted Area</u></p> <p>Extension cord was removed from Room #333 on 12/14/11, and a solid cord was installed from the heating unit to the plug.</p> <p>The extension cords that were outside the facility were removed on 12/14/11 and a new ground fault receptacle was installed on 12/20/11 that was used to power the outdoor extension cord.</p> <p><u>Identification of Areas with Potential to be Affected</u></p> <p>The Maintenance Director conducted an inspection of the facility on 12/20/11 and did not find any other areas to be affected.</p> <p><u>Systematic Changes</u></p> <p>Staff will be In-serviced by the Maintenance Director on 1/13/12 regarding the facility's requirement that no extension cords will be used in resident care areas.</p>	

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K 147	Continued From page 11 adapters. Reference: NFPA 70 (1999 edition) Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Reference: NFPA 70 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel. FPN: See 215.9 for ground-fault circuit-interrupter protection for personnel on feeders. (A) Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1) through (B) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms	K 147	<u>Monitoring</u> The Maintenance Director will conduct a monthly inspection of the facility. Findings will be reported to the Performance Improvement Committee on a quarterly basis for review and determination of ongoing compliance. This committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.	1/29/12	

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K 147	Continued From page 12 (2) Garages, and also accessory buildings that have a floor located at or below grade level not intended as habitable rooms and limited to storage areas, work areas, and areas of similar use Exception No. 1: Receptacles that are not readily accessible. Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Receptacles installed under the exceptions to 210.8(A)(2) shall not be considered as meeting the requirements of 210.52(G). (3) Outdoors Exception: Receptacles that are not readily accessible and are supplied by a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426. (4) Crawl spaces - at or below grade level (5) Unfinished basements - for purposes of this section, unfinished basements are defined as portions or areas of the basement not intended as habitable rooms and limited to storage areas, work areas, and the like Exception No. 1: Receptacles that are not readily accessible. Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Exception No. 3: A receptacle supplying only a	K 147		

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K 147	Continued From page 13 permanently installed fire alarm or burglar alarm system shall not be required to have ground-fault circuit-interrupter protection. Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G). (6) Kitchens - where the receptacles are installed to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink. (8) Boathouses (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1), (2), and (3) shall have ground-fault circuit-interrupter protection for personnel: (1) Bathrooms (2) Rooftops Exception: Receptacles that are not readily accessible and are supplied from a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426. (3) Kitchens.	K 147		