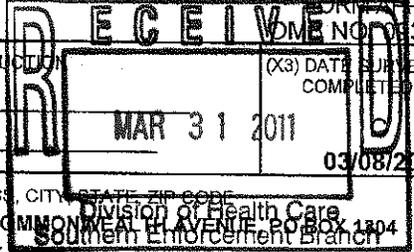


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2011

UNAPPROVED
NON-38-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2011
--	--	--	--



NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEAL AVENUE, BOX 1804 CORBIN, KY 40702
---	--

(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 --AMENDED An abbreviated standard survey (KY16044) was conducted on March 2-8, 2011. The allegation was substantiated. Immediate Jeopardy was identified on March 2, 2011, and was determined to exist on February 6, 2011. The facility was notified of the Immediate Jeopardy on March 2, 2011. A partial extended survey was conducted on March 7-8, 2011. Deficient practice was identified at 483.13 Resident Behavior and Facility Practices (F224) at a scope/severity of "J" and 483.25 Quality of Care (F309) at a scope/severity of "J," which also constituted Substandard Quality of Care. **An acceptable allegation of compliance was received on March 8, 2011, which alleged removal of Immediate Jeopardy on March 4, 2011. The partial extended survey conducted on March 7-8, 2011, determined the Jeopardy was removed on March 5, 2011. The scope/severity for F224 and F309 was lowered to "D." Per CMS consultation, the scope/severity for 483.13 Resident Behavior and Facility Practices (F226) was increased to "J" and 483.75 Administration (F490) was added at a scope/severity of "J."	F 000	Preparation and execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required by the provision of federal and state law. F224 1. Resident #1 expired in the building on February 6, 2011. 2. On February 7, 2011 all current residents' records were audited by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Coordinators (UC's) for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) to determine the residents code status is appropriately documented and to ensure the forms were signed by the resident, Power of Attorney (POA), or Guardian as applicable. All charts were verified to contain the correct code status for the residents. 3. On March 2, 2011 the Administrator and DON reviewed the Abuse and Neglect Policy and Procedure. The Code Status Policy was reviewed and revised by the Administrator and Director of Nursing February 7, 2011. The revised Code Status Policy provides a more detailed explanation on the services to provide or actions to be taken when a resident is found unresponsive.	
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bell Collins</i>	TITLE Administrator	(X6) DATE 3/31/11
--	------------------------	----------------------

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

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 224	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide goods and services necessary to avoid physical harm for one (1) of six (6) sampled residents (resident #1). On February 6, 2011, resident #1 was found unresponsive and not breathing. The facility failed to administer Cardiopulmonary Resuscitation (CPR) to resident #1 who had a physician's order for Full Code Status, and a notarized Confirmation of Full Code Status. Resident #1 expired at the facility on February 6, 2011. The facility's failure to ensure that necessary services to avoid physical harm were administered placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on February 6, 2011. The findings include: Review of the facility's Abuse Reporting and Prevention policy/procedure, updated July 2001, revealed that neglect was failure to provide goods and services necessary to avoid physical harm. Review of resident #1's medical record and the facility's investigation, dated February 7, 2011, revealed resident #1 was discovered by staff to be unresponsive and not breathing on February 6, 2011. Registered Nurse (RN) #1 was summoned to resident #1's room, and confirmed resident #1 was without blood pressure, pulse, or	F 224	RN #1 was provided individual in-servicing on February 7, 2011 on the revised Code Status Policy. On March 2, 2011 RN # 1 was re-educated on the Abuse and Neglect Policy and Procedure including how to identify and report suspected abuse and neglect. The Administrator and Director of nursing were re-inserviced on identification and investigation of abuse and neglect as well as their duty to report suspected abuse and neglect to the appropriate agencies timely, as done by the Staff Development Coordinator, on March 2, 2011. The Administrator, Director of Nursing, Staff Development Coordinator, and Unit Coordinators conducted re-education related to abuse and neglect prevention and reporting for all employees March 2 -4, 2011. New employees will be in-serviced related to abuse/neglect prevention and reporting while in orientation by the Staff Development Coordinator (SDC). The SDC will provide re-education to staff related to Abuse and Neglect prevention and reporting monthly for three months, then as directed by the Quality Assurance committee. 4. The Administrator will interview five residents weekly to determine if there have been any instances of perceived abuse or neglect. The administrator will also interview five staff members weekly in an effort to monitor for instances of perceived		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 224	<p>Continued From page 2</p> <p>respirations; however, RN #1 failed to administer CPR to resident #1.</p> <p>Review of RN #1's signed statement, dated February 7, 2011, and interview with RN #1 on March 2, 2011, at 10:50 a.m., revealed RN #1 "remembered thinking [resident #1] was in such a better place and wasn't suffering anymore. I was thinking [he/she] was a DNR (do not resuscitate)." Further review of the written statement and interview with RN #1 revealed no action was taken to confirm resident #1's code status in the medical record, stating "in my mind [he/she] was a DNR." Per interview, RN #1 did not know resident #1 required administration of all life sustaining/resuscitative measures possible to maintain life, until at least 15 minutes after the resident had been assessed to have no signs of life. RN #1 stated, "By that time it had been too long to do CPR."</p> <p>Interview with the Director of Nursing on March 2, 2011, at 1:45 p.m. and 3:00 p.m., revealed he/she became aware that RN #1 failed to perform resuscitative measures to resident #1 on February 6, 2011, when he/she was contacted at home regarding the incident. The DON stated it was immediately recognized that CPR should have been initiated to resident #1, however, the DON stated he/she failed to consider RN #1's actions as being neglectful, and considered the incident a "mistake" made by RN #1.</p> <p>Review of resident #1's medical record revealed on February 6, 2011, resident #1 had a current signed physician's order for Full Code Status, and a notarized Confirmation of Full Code Status present in the resident's medical record. Interview with resident #1's state appointed</p>	F 224	<p>neglect/abuse in cognitively impaired residents for the next three months, then as directed by the Quality Assurance Committee. The DON, ADON and/or UC will visually audit nine residents weekly for three months to ensure that there are no indications of abuse / neglect, then as directed by the Quality Assurance Committee.</p> <p>The Administrator will review the audit findings and report to the Quality Assurance Committee monthly. The monthly QA Committee findings will be reviewed by the Medical Director at the quarterly QA Committee meeting to evaluate the effectiveness of the actions taken.</p>	3/31/11	

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 224	<p>Continued From page 3</p> <p>Guardian on March 2, 2011, at 2:20 p.m., confirmed resident #1 was a "full code" and all measures necessary to revive/sustain the life of resident #1 should have been taken (refer to F309).</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on March 8, 2011, which alleged removal of Immediate Jeopardy effective March 4, 2011. A partial extended survey was conducted on March 7-8, 2011, which determined the Immediate Jeopardy was removed on March 5, 2011.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>Resident #1 expired at the facility on February 6, 2011. On February 7, 2011, all current residents' charts were audited by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Coordinators (UC) for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) forms to ensure the forms were signed by resident, Power of Attorney (POA), or Guardian as applicable. All charts were verified to contain the correct code status for the resident.</p> <p>The Abuse and Neglect Policy and Procedure was reviewed by the Administrator and DON on March 2, 2011.</p> <p>RN #1 received individual in-servicing on February 7, 2011, on the revised code policy and procedure.</p> <p>Education/training related to abuse/neglect</p>	F 224			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 224	<p>Continued From page 4</p> <p>prevention and reporting was conducted for all employees on March 2-4, 2011, by the Staff Development Coordinator (SDC), DON, ADON, UCs, and Administrator.</p> <p>The Administrator and DON were re-educated regarding their responsibilities to report suspected abuse/neglect when identified by the SDC on March 2, 2011.</p> <p>New employees will be in-serviced related to abuse/neglect prevention and reporting while in orientation.</p> <p>Ongoing in-servicing related to abuse and neglect prevention/reporting will be provided to nursing staff by the SDC monthly for three months then as directed by the Quality Assurance (QA) Committee.</p> <p>The Administrator will interview five residents and five staff members weekly to determine if any perceived instances of abuse/neglect have occurred. The DON, ADON, and/or UC will visually audit nine residents weekly for three months to ensure there are no indications of abuse/neglect. The Administrator will review the audits with the QA committee, who will direct continued visual audits.</p> <p>The surveyor validated the corrective action taken by the facility as follows:</p> <p>Review of Code Status Review forms dated February 7, 2011, and interviews conducted on March 8, 2011, with the DON, ADON, and UC revealed all resident charts were audited for correct code status, appropriate physician's orders, and signed EMS forms on February 7,</p>	F 224		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 224	<p>Continued From page 5</p> <p>2011. Additionally, a review of five resident charts on March 7, 2011, revealed the charts were designated with the appropriate code status, contained physician's orders, and contained a signed EMS form.</p> <p>Interviews with the Administrator and DON on March 8, 2011, revealed the review of the abuse and neglect policy and procedure conducted on March 2, 2011, revealed no identified concerns. Additionally, a copy of the Abuse Reporting and Prevention policy/procedure signed and dated March 2, 2011, by the Administrator and DON was reviewed.</p> <p>Review of a Counseling/Discipline Record for RN #1 dated February 25, 2011, and an interview with RN #1 on March 2, 2011, revealed RN #1 was educated regarding the revised code status policy/procedure on February 7, 2011. A review of the Abuse/Neglect policy in-service revealed RN #1 received training on the Abuse/Neglect policy/procedure on March 2, 2011.</p> <p>Review of On the Spot Education/Re-education forms dated March 2, 3, and 4, 2011, and interviews with the SDC, DON, ADON, UCs, and Administrator on March 8, 2011, revealed staff had been in-serviced, including RN #1, regarding the abuse/neglect policy and procedure. Additionally, interviews on March 7-8, 2011, with RN #2, Licensed Practical Nurse (LPN) #3, Certified Nursing Assistants (CNAs) #1, #2, and #3, and the Certified Medication Technician (CMT) on March 8, 2011, revealed all the staff interviewed had attended training on the abuse neglect policy/procedure on either March 2, 3, or 4, 2011.</p>	F 224		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 224	<p>Continued From page 6</p> <p>Review of an On the Spot Education/Re-education dated March 2, 2011, and interviews with the Administrator and DON on March 8, 2011, revealed the SDC had re-educated the Administrator and DON of their ultimate responsibility to report allegations of abuse and neglect to the appropriate agencies timely.</p> <p>Review of a facility's Orientation Checklist and interview with the DON on March 8, 2011, revealed new employees would be trained regarding the facility's abuse/neglect policy/procedure including prevention and reporting during the facility orientation.</p> <p>Review of a Monthly Education form and interview with the DON on March 8, 2011, revealed the facility had scheduled abuse/neglect training for March, April, and May 2011.</p> <p>Review of QA Audits: Perceived Neglect or Abuse Allegations dated March 4, 2011, and signed by the Administrator, and interview with the Administrator on March 8, 2011, revealed five residents and five staff persons were interviewed regarding any perceived abuse or neglect incidents with no concerns identified. Additionally, a review of Quality Assurance: Round Audit Tools dated March 4, 2011, and interviews with the DON, ADON, and UC on March 8, 2011, revealed nine residents were reviewed on March 4, 2011, for any signs/symptoms of neglect with no concerns identified.</p> <p>Based on the above findings, it was determined the Immediate Jeopardy was removed on March 5, 2011. Noncompliance continued with the</p>	F 224			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 224	Continued From page 7 scope and severity lowered to "D" based on the facility's need to evaluate the effectiveness of Quality Assurance activities related to the implementation of policies and procedures for ensuring residents were free from abuse/neglect and ensuring the facility provided the necessary care and services to maintain each resident's physical wellbeing.	F 224	Preparation and execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required by the provision of federal and state law.		
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement policies and procedures for reporting an incident of possible neglect for one (1) of six (6) sampled residents (resident #1). Although the facility conducted an investigation regarding the failure of staff to administer Cardiopulmonary Resuscitation (CPR) to resident #1 who was to receive all life sustaining/resuscitative measures possible, the facility failed to report the incident as an act of possible negligence to appropriate agencies as required. The facility's failure to ensure all possible instances of neglect were reported to appropriate agencies as required placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on February 6, 2011.	F 226	F226 1. Resident #1 expired in the building on February 6, 2011. 2. On February 7, 2011 all current residents' records were audited by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Coordinators (UC's) for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) to determine the residents code status is appropriately documented and to ensure the forms were signed by the resident, Power of Attorney (POA), or Guardian as applicable. All charts were verified to contain the correct code status for the residents. 3. On March 2, 2011 the Administrator and DON reviewed the Abuse and Neglect Policy and Procedure. On March 2, 2011 RN # 1 was re-educated on the Abuse and Neglect Policy and Procedure including how to identify and report suspected abuse. The Administrator and Director of nursing were re-inserviced on identification and investigation of abuse and neglect as well as their duty to		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 226	<p>Continued From page 8</p> <p>The findings include:</p> <p>Review of a facility investigation dated February 7, 2011, revealed resident #1 was discovered to be unresponsive and not breathing on February 6, 2011. Resident #1 had physician's orders for and a notarized confirmation of full code status. However, Registered Nurse (RN) #1 who was summoned to the resident's room "thought" resident #1 had a DNR order, and failed to initiate resuscitative measures to the resident.</p> <p>Review of the facility's Abuse Reporting and Prevention policy/procedure, updated July 2001, revealed that neglect was failure to provide goods and services necessary to avoid physical harm, and was required to be reported immediately to appropriate state agencies.</p> <p>Interview with the Director of Nursing on March 2, 2011, at 1:45 p.m. and 3:00 p.m., revealed he/she became aware that resuscitative measures had not been administered to resident #1, despite the resident being a "full code" on February 6, 2011, when he/she was contacted at home regarding the incident. The DON stated it was immediately recognized that CPR should have been initiated to resident #1, and a facility investigation was initiated to determine why RN #1 failed to initiate resuscitative measures to resident #1. However, the facility failed to report the incident to any outside agencies as a possible act of negligence to resident #1.</p> <p>The DON further revealed in the interview on March 2, 2011, at 1:45 p.m. and 3:00 p.m., that the facility's investigation determined resident #1 would not have wanted life</p>	F 226	<p>report suspected abuse and neglect to the appropriate agencies timely, as done by the Staff Development Coordinator, on March 2, 2011.</p> <p>The Administrator, Director of Nursing, Staff Development Coordinator, and Unit Coordinators conducted re-education related to abuse and neglect prevention and reporting for all employees March 2 -4, 2011.</p> <p>New employees will be in-serviced related to abuse/neglect prevention and reporting while in orientation by the Staff Development Coordinator (SDC). The SDC will provide re-education to staff related to Abuse and Neglect prevention and reporting monthly for three months, then as directed by the Quality Assurance committee.</p> <p>4. The Administrator will interview five residents weekly to determine if there have been any instances of perceived abuse or neglect. The administrator will also interview five staff members weekly in an effort to monitor for instances of perceived neglect/abuse in cognitively impaired residents for the next three months, then as directed by the Quality Assurance Committee. The DON, ADON and/or UC will visually audit nine residents weekly for three months to ensure that there are no indications of abuse / neglect, then as directed by the Quality Assurance Committee.</p> <p>The Administrator will review the audit findings and report to the Quality Assurance Committee</p>		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 226	<p>Continued From page 9</p> <p>sustaining/resuscitative measures initiated, and was only a "full code" due to having been appointed a State Guardian which required the resident to be a "full code." Therefore, according to the DON the facility did not feel the failure to initiate Cardiopulmonary Resuscitation to resident #1 was neglectful despite the resident having physician's orders and a signed notarized confirmation that all possible life sustaining/resuscitative measures were to be provided, and did not report the incident to state agencies (refer to F224).</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on March 8, 2011, which alleged removal of Immediate Jeopardy effective March 4, 2011. A partial extended survey was conducted on March 7-8, 2011, which determined the Immediate Jeopardy was removed on March 5, 2011.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>Resident #1 expired at the facility on February 6, 2011. On February 7, 2011, all current residents' charts were audited by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Coordinators (UC) for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) forms to ensure the forms were signed by the resident, Power of Attorney (POA), or Guardian as applicable. All charts were verified to contain the correct code status for the resident.</p> <p>The Abuse and Neglect Policy and Procedure was reviewed by the Administrator and DON on</p>	F 226	<p>monthly. The monthly QA Committee findings will be reviewed by the Medical Director at the quarterly QA Committee meeting to evaluate the effectiveness of the actions taken.</p>	3/31/11	

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 226	<p>Continued From page 10 March 2, 2011.</p> <p>RN #1 received individual in-servicing on February 7, 2011, on the revised code policy and procedure.</p> <p>Education/training related to abuse/neglect prevention and reporting was conducted for all employees on March 2-4, 2011, by the Staff Development Coordinator (SDC), DON, ADON, UCs, and Administrator.</p> <p>The Administrator and DON were re-educated regarding their responsibilities to report suspected abuse/neglect when identified by the SDC on March 2, 2011.</p> <p>New employees will be in-serviced related to abuse/neglect prevention and reporting while in orientation.</p> <p>Ongoing in-servicing related to abuse and neglect prevention/reporting will be provided to nursing staff by the SDC monthly for three months then as directed by the Quality Assurance (QA) Committee.</p> <p>The Administrator will interview five residents and five staff members weekly to determine if any perceived instances of abuse/neglect have occurred. The DON, ADON, and/or UC will visually audit nine residents weekly for three months to ensure there are no indications of abuse/neglect. The Administrator will review the audits with the QA committee, who will direct continued visual audits.</p> <p>The surveyor validated the corrective action taken by the facility as follows:</p>	F 226			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 226	<p>Continued From page 11</p> <p>Review of Code Status Review forms dated February 7, 2011, and interviews conducted on March 8, 2011, with the DON, ADON, and UC revealed all resident charts were audited for correct code status, appropriate physician's orders, and signed EMS forms on February 7, 2011. Additionally, a review of five resident charts on March 7, 2011, revealed the charts were designated with the appropriate code status, contained physician's orders, and contained a signed EMS form.</p> <p>Interviews with the Administrator and DON on March 8, 2011, revealed the review of the abuse and neglect policy and procedure conducted on March 2, 2011, revealed no identified concerns. Additionally, a copy of the Abuse Reporting and Prevention policy/procedure signed and dated March 2, 2011, by the Administrator and DON was reviewed.</p> <p>Review of a Counseling/Discipline Record for RN #1 dated February 25, 2011, and an interview with RN #1 on March 2, 2011, revealed RN #1 was educated regarding the revised code status policy/procedure on February 7, 2011. A review of the Abuse/Neglect policy in-service revealed RN #1 received training on the Abuse/Neglect policy/procedure on March 2, 2011.</p> <p>Review of On the Spot Education/Re-education forms dated March 2, 3, and 4, 2011, and interviews with the SDC, DON, ADON, UCs, and Administrator on March 8, 2011, revealed staff had been in-serviced, including RN #1, regarding the abuse/neglect policy and procedure. Additionally, interviews on March 7-8, 2011, with RN #2, Licensed Practical Nurse (LPN) #3,</p>	F 226			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 226	<p>Continued From page 12</p> <p>Certified Nursing Assistants (CNAs) #1, #2, and #3, and the Certified Medication Technician (CMT) on March 8, 2011, revealed all the staff interviewed had attended training on the abuse neglect policy/procedure on either March 2, 3, or 4, 2011.</p> <p>Review of an On the Spot Education/Re-education dated March 2, 2011, and interviews with the Administrator and DON on March 8, 2011, revealed the SDC had re-educated the Administrator and DON of their ultimate responsibility to report allegations of abuse and neglect to the appropriate agencies timely:</p> <p>Review of a facility's Orientation Checklist and interview with the DON on March 8, 2011, revealed new employees would be trained regarding the facility's abuse/neglect policy/procedure including prevention and reporting during the facility orientation.</p> <p>Review of a Monthly Education form and interview with the DON on March 8, 2011, revealed the facility had scheduled abuse/neglect training for March, April, and May 2011.</p> <p>Review of QA Audits: Perceived Neglect or Abuse Allegations dated March 4, 2011, and signed by the Administrator, and interview with the Administrator on March 8, 2011, revealed five residents and five staff persons were interviewed regarding any perceived abuse or neglect incidents with no concerns identified. Additionally, a review of Quality Assurance: Round Audit Tools dated March 4, 2011, and interviews with the DON, ADON, and UC on March 8, 2011, revealed nine residents were</p>	F 226			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 226	Continued From page 13 reviewed on March 4, 2011, for any signs/symptoms of neglect with no concerns identified. Based on the above findings, it was determined the Immediate Jeopardy was removed on March 5, 2011. Noncompliance continued with the scope and severity lowered to "D" based on the facility's need to evaluate the effectiveness of Quality Assurance activities related to the implementation of policies and procedures for ensuring residents were free from abuse/neglect and ensuring the facility provided the necessary care and services to maintain each resident's physical wellbeing.	F 226	Preparation and execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required by the provision of federal and state law.		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide care and services to maintain physical wellbeing for one (1) of six (6) sampled residents (resident #1). Resident #1 was found unresponsive and not breathing on February 6, 2011. The facility failed to ensure Cardiopulmonary Resuscitation (CPR) was administered to resident #1 who had a Full Code Status. Resident #1 expired at the facility on February 6, 2011.	F 309	F309 1. Resident #1 expired in the building on February 6, 2011. 2. On February 7, 2011 all current residents' records were audited by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Coordinators (UC's) for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) to determine the residents code status is appropriately documented and to ensure the forms were signed by the resident, Power of Attorney (POA), or Guardian as applicable. All charts were verified to contain the correct code status for the residents. 3. The Code Status Policy was reviewed and revised by the Administrator and Director of Nursing February 7, 2011. The revised Code Status Policy provides a more detailed explanation on the services to provide or actions to be taken when a resident is found unresponsive.		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 309	<p>Continued From page 14</p> <p>The failure of the facility to ensure care and services to maintain physical wellbeing was provided for residents placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on February 6, 2011.</p> <p>The findings include:</p> <p>Review of the facility's Cardiopulmonary Resuscitation (CPR) Policy and Procedure, dated February 1999, revealed the document addressed the correct clinical steps to be performed when administering CPR, but failed to address actions expected to be taken when a resident was found unresponsive and not breathing to ensure the correct code status was followed by facility staff.</p> <p>Review of resident #1's medical record revealed the facility admitted resident #1 on June 9, 2009, with diagnoses including Alzheimer's Disease, Parkinson's Disease, and Renal Disease. The resident had been adjudicated incompetent, appointed a State Guardian, and had physician's orders for "Full Code" and a notarized Confirmation of Full Code Status.</p> <p>Review of the facility's investigation dated February 7, 2011, revealed on February 6, 2011, RN #1 was summoned to resident #1's room by a Certified Nursing Assistant who found resident #1 unresponsive and not breathing. RN #1 confirmed the resident to be without blood pressure, pulse, or respirations; however, CPR was not administered to resident #1.</p>	F 309	<p>The Medical Director reviewed and approved the revised Code Status Policy.</p> <p>Current CPR Certification was checked for Licensed Nurses. Additional Renewal classes were held on February 16 and 17, 2011.</p> <p>RN #1 was provided individual in-servicing on February 7, 2011 on the revised Code Status Policy. On March 2, 2011 RN #1 was re-educated on the Abuse and Neglect Policy and Procedure including how to identify and report suspected abuse and neglect.</p> <p>All Nursing Staff were educated on February 7, 2011 by the Staff Development Coordinator on the revised Code Status Policy.</p> <p>New employees will be in-serviced while in orientation related to the guidelines for determining if a resident is a full code and how to promptly identify each resident's code status and what actions to take if the resident is a full code or a DNR.</p> <p>On going in-servicing related to guidelines for determining if a resident is a full code, how to promptly identify each resident's code status and what actions to take if the resident is a full code or a DNR will be conducted by the Staff Development Coordinator monthly for three months. Then will proceed as directed by the Quality Assurance committee.</p> <p>4. The DON, ADON, and Unit Coordinators will conduct a mock code weekly for one month on diverse shifts to ensure that the staff follows the facilities guidelines on a full code and DNR</p>		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 309	<p>Continued From page 15</p> <p>Review of a signed statement by RN #1 dated February 7, 2011, and interview with RN #1 on March 2, 2011, at 10:50 a.m., revealed RN #1 "thought" resident #1 was a DNR, although the resident's chart was clearly labeled the resident was a full code. Interview with the Director of Nursing (DON) on March 2, 2011, at 1:45 p.m. and 3:00 p.m., revealed the facility had conducted no training or monitoring to ensure staff was checking residents' charts to identify residents' code status prior to making a decision if CPR would be initiated when a resident was found unresponsive and not breathing.</p> <p>Interview with the DON on March 2, 2011, at 1:45 p.m. and 3:00 p.m., revealed the facility did not have a policy/procedure in place prior to February 6, 2011, that instructed staff on appropriate actions to take to ensure the proper code status was followed when a resident was found unresponsive and not breathing. According to the DON and a review of facility's in-services revealed the facility staff had participated in CPR certification classes in December 2005 and October 2007; however, the facility had not conducted training or elicited staff competency regarding correctly determining code status of an individual resident.</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on March 8, 2011, which alleged removal of Immediate Jeopardy effective March 4, 2011. A partial extended survey was conducted on March 7-8, 2011, which determined the Immediate Jeopardy was removed on March 5, 2011.</p> <p>A review of the allegation of compliance revealed</p>	F 309	<p>resident as outlined on the revised Code Status Policy. Thereafter, the mock codes will be conducted every two weeks for one month, then quarterly.</p> <p>The DON will interview five staff members weekly for one month to ensure the employees are aware of how to determine if a resident is a full code or DNR and what actions should be taken dependent upon the resident's code status. Thereafter, the DON will audit five staff members monthly for three months to ensure the staff is aware of the process for a full code and/or a DNR situation, then as determined by the Quality Assurance Committee.</p> <p>The Director of Nursing or ADON will audit all new admissions and 4 other charts for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) to determine the residents code status is appropriately documented and to ensure the forms were signed by the resident, Power of Attorney (POA), or Guardian as applicable weekly for three months, monthly for three months, then as determined by the QA Committee. The Medical records clerk will audit all charts monthly for three months to determine if the charts contains the physicians order and is clearly labeled with the correct code status.</p> <p>The Administrator will review the audit findings and report to the Quality Assurance Committee monthly. The monthly QA Committee findings will be reviewed by the Medical Director at the quarterly QA Committee meeting to evaluate the effectiveness of the actions taken.</p>	3/31/11	

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 309	<p>Continued From page 16 the following:</p> <p>Resident #1 expired at the facility on February 6, 2011. On February 7, 2011, all current residents' charts were audited by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Coordinators (UC) for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) forms to ensure the forms were signed by the resident, Power of Attorney (POA), or Guardian as applicable. All charts were verified to contain the correct code status for the resident.</p> <p>The Code Status Policy was reviewed and revised by the Administrator and DON on February 7, 2011. Current CPR Certification was validated for all licensed nurses on February 7, 2011, and subsequent renewal classes were held on February 16 and 17, 2011.</p> <p>RN #1 received individual in-servicing on February 7, 2011, on the revised code policy and procedure.</p> <p>All Nursing staff was educated on February 7, 2011, by the Staff Development Coordinator (SDC) on the revised Code Policy.</p> <p>New employees will be in-serviced while in orientation related to the guidelines for determining if a resident is a full code and how to promptly identify each resident's code status and what actions to take if the resident is a full code or DNR.</p> <p>Ongoing in-servicing related to guidelines for determining if a resident is a full code and how to promptly identify each resident's code status and</p>	F 309		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 309	<p>Continued From page 17</p> <p>what actions to take if the resident is a full code or DNR will be conducted by the SDC monthly for three months and then as directed by the Quality Assurance (QA) Committee.</p> <p>The Medical Director was consulted and reviewed the Revised Code Status Policy and Procedure on March 3, 2011.</p> <p>The DON will interview five staff members weekly for one month to ensure the employees are aware of how to determine if a resident is a full code or a DNR and what action should be taken dependent upon the resident's code status. Additionally, the DON, ADON, and UC will conduct a mock code weekly for one month on diverse shifts to ensure that staff follows the facility's Revised Code Status policy and procedure. Thereafter, the mock codes will be conducted every two weeks for one month, and then conducted quarterly.</p> <p>The DON will audit all new admissions and four additional charts weekly to determine the resident's appropriate code status is clearly documented and all forms are contained in the resident's medical record. The Medical records clerk will audit all charts monthly for three months to determine if the medical record contains physician's orders and is clearly labeled with the correct code status.</p> <p>The surveyor validated the corrective action taken by the facility as follows:</p> <p>Review of Code Status Review forms dated February 7, 2011, and interviews conducted on March 8, 2011, with the DON, ADON, and UC revealed all resident charts were audited for correct code status, appropriate physician's</p>	F 309		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 309	<p>Continued From page 18</p> <p>orders, and signed EMS forms on February 7, 2011. Additionally, a review of five resident charts on March 7, 2011, revealed the charts were designated with the appropriate code status, contained physician's orders, and contained a signed EMS form.</p> <p>Review of the revised Code policy and procedure including the Full Code Status versus No Code-DNR revision dated February 7, 2011, revealed the policy and procedure contained specifics regarding decisions of code status by the resident/family, what must be documented in the medical record, what designation of a "full code" entailed, and specific instructions for staff to utilize when a resident was found unresponsive to ensure the resident's correct code status was initiated. Additionally, a review of Current and Expiration of CPR Certification and interview with the DON on March 8, 2011, revealed that a review of all licensed staff 's CPR certification was conducted and as of February 17, 2011, all licensed staff was certified in CPR.</p> <p>Review of a Counseling/Discipline Record for RN #1 dated February 25, 2011, and interview with RN #1 on March 2, 2011, revealed RN #1 was educated regarding the revised code status policy/procedure on February 7, 2011.</p> <p>Review of Upstairs Solutions DNR/No Code Policy and Procedure training dated February 7, 2011, and interview with the SDC on March 8, 2011, revealed nursing staff had been in-serviced regarding the revised Code Policy. Additionally, interviews on March 2-8, 2011, with RN #2, Licensed Practical Nurse (LPN) #2, LPN #3, Certified Nursing Assistants (CNAs) #1, #2, and #3, and a Certified Medication Technician (CMT)</p>	F 309			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 309	<p>Continued From page 19</p> <p>revealed staff had received training regarding the Revised Code Policy on February 7, 2011.</p> <p>Review of a facility Orientation Checklist and interview with the DON on March 8, 2011, revealed new employees would be trained regarding the facility's revised CPR policy and CPR Certification during facility orientation.</p> <p>Interview with the DON on March 8, 2011, revealed the facility had scheduled training regarding the facility's revised CPR policy and procedure for March, April, and May 2011.</p> <p>Review of the Revised Code Status Policy and Procedure revealed the Medical Director's signature verifying review and approval of the document on March 3, 2011.</p> <p>Review of QA Mock Full Code Status forms and interview with the DON on March 8, 2011, revealed staff was able to answer the mock code questions appropriately on March 3, 2011, and appropriately performed a Mock code simulation on March 7, 2011. Additionally, interviews conducted on March 2-8, 2011, with RN #1, RN #2, LPN #2, LPN #3, LPN #4, LPN #6, CNA #1, CNA #2, CNA #3, CMT #1, and LPN #5 revealed staff was knowledgeable and able to verbalize all parts/steps in the facility's Revised Code Status in regards to acting appropriately in a code situation.</p> <p>Review of a QA Code Status dated March 2, 2011, and interview with the DON on March 8, 2011, revealed ten resident charts were reviewed with no concerns identified related to appropriate physician's orders and labeling of the chart in regard to code status. Additionally, a review of five resident charts on March 7, 2011, revealed</p>	F 309			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 309	Continued From page 20 the charts were designated with the appropriate code status, and contained physician's orders for the appropriate code status. Based on the above findings, it was determined the Immediate Jeopardy was removed on March 5, 2011. Noncompliance continued with scope and severity lowered to "D" based on the facility's need to evaluate the effectiveness of Quality Assurance activities related to the implementation of policies and procedures for ensuring residents were free from abuse/neglect and ensuring the facility provided the necessary care and services to maintain each resident's physical wellbeing.	F 309	F490 Preparation and execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required by the provision of federal and state law.		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the Administrator failed to effectively administer the facility in a manner that promoted the highest physical wellbeing of each resident. The facility's administration failed to ensure the Cardiopulmonary Resuscitation (CPR) Policy and Procedure detailed actions staff would take to ensure correct code status was followed in the event a resident was found unresponsive and not breathing. Furthermore, this failure resulted in the facility's failure to ensure staff was knowledgeable regarding the procedures. On February 6, 2011, facility staff found resident #1	F 490	1. Resident #1 expired in the building on February 6, 2011. 2. On February 7, 2011 all current residents' records were audited by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Coordinators (UC's) for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) to determine the residents code status is appropriately documented and to ensure the forms were signed by the resident, Power of Attorney (POA), or Guardian as applicable. All charts were verified to contain the correct code status for the residents. 3. The Code Status Policy was reviewed and revised by the Administrator and Director of Nursing February 7, 2011. The revised Code Status Policy provides a more detailed explanation on the services to provide or		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 490	<p>Continued From page 21</p> <p>unresponsive and not breathing. Registered Nurse (RN) #1 "thought" the resident was a "do not resuscitate" (DNR), failed to confirm the resident's code status, and neglected to administer the resident cardiopulmonary resuscitation (CPR). Resident #1 expired at the facility on February 6, 2011 (refer to F224, F226, and F309). Although the facility conducted an investigation regarding the failure of staff to administer Cardiopulmonary Resuscitation (CPR) to resident #1 who was to receive all life sustaining/resuscitative measures possible, the facility failed to identify neglect and failed to report the incident as an act of possible negligence to appropriate state agencies as required.</p> <p>These facility failures placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on February 6, 2011, at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care, and Immediate Jeopardy at 483.75 Administration.</p> <p>The findings include:</p> <p>A review of the facility's Cardiopulmonary Resuscitation (CPR) Policy and Procedure, dated February 1999, revealed the document addressed the correct clinical steps to be performed when administering CPR, but failed to address actions expected to be taken when a resident was found unresponsive and not breathing to ensure the correct code status was followed by facility staff.</p> <p>Review of the facility's investigation dated February 7, 2011, revealed on February 6, 2011, RN #1 was summoned to resident #1's room by a</p>	F 490	<p>actions to be taken when a resident is found unresponsive.</p> <p>The Medical Director reviewed and approved the revised Code Status Policy.</p> <p>On March 2, 2011 the Administrator and DON reviewed the Abuse and Neglect Policy and Procedure.</p> <p>The Administrator and Director of nursing were re-inserviced on identification and investigation of abuse and neglect as well as their duty to report suspected abuse and neglect to the appropriate agencies timely, as done by the Staff Development Coordinator, on March 2, 2011</p> <p>The Administrator reviewed and acknowledged his job description with the Vice President of Older Adults on 3/30/11.</p> <p>RN #1 was provided individual in-servicing on February 7, 2011 on the revised Code Status Policy. On March 2, 2011 RN # 1 was re-educated on the Abuse and Neglect Policy and Procedure including how to identify and report suspected abuse and neglect.</p> <p>Current CPR Certification was checked for Licensed Nurses. Additional Renewal classes were held on February 16 and 17, 2011 All Nursing Staff were educated on February 7, 2011 by the Staff Development Coordinator on the revised Code Status Policy.</p> <p>New employees will be in-serviced while in orientation related to: the guidelines for</p>		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 490	<p>Continued From page 22</p> <p>Certified Nursing Assistant who found resident #1 unresponsive and not breathing. RN #1 confirmed the resident to be without blood pressure, pulse, or respirations; however, CPR was not administered to resident #1. Review of a signed statement by RN #1 dated February 7, 2011, and interview with RN #1 on March 2, 2011, at 10:50 a.m., revealed RN #1 "thought" resident #1 was a DNR, although the resident's chart was clearly labeled the resident was a full code.</p> <p>Interviews conducted on March 2, 2011, at 1:45 p.m. and 3:00 p.m., with the DON revealed he/she was notified of the incident on February 6, 2011, and immediately recognized that CPR should have been initiated to resident #1. However, the DON stated he/she failed to consider RN #1's actions as being neglectful, viewing the incident as a "mistake," and did not report the failure to initiate CPR to resident #1 as an act of possible neglect as required. The DON stated at the conclusion of the investigation it was determined resident #1 would not have wanted life sustaining/resuscitative measures initiated, and was only a "full code" due to having been appointed a State Guardian which required the resident to be a "full code." Therefore, according to the DON the facility "actually did the right thing" despite the resident having physician's orders and a signed notarized confirmation that all possible life sustaining/resuscitative measures were to be provided. The DON stated the facility did not conduct training or elicit staff competency for determining code status of an individual resident prior to February 6, 2011. Additionally, the DON stated he/she did not realize the policy/procedure had not been reviewed/revise since 1999, and did not address confirming a resident's code status until February 7, 2011, when the incident</p>	F 490	<p>determining if a resident is a full code and how to promptly identify each resident's code status and what actions to take if the resident is a full code or a DNR, and abuse/neglect prevention and reporting by the Staff Development Coordinator (SDC).</p> <p>On going in-servicing related to guidelines for determining if a resident is a full code, how to promptly identify each resident's code status and what actions to take if the resident is a full code or DNR and abuse/neglect prevention and reporting will be conducted by the Staff Development Coordinator monthly for three months. Then will proceed as directed by the Quality Assurance committee.</p> <p>4. The DON, ADON, and Unit Coordinators will conduct a mock code weekly for one month on diverse shifts to ensure that the staff follows the facilities guidelines on a full code and DNR resident as outlined on the Code Status Policy. Thereafter, the mock codes will be conducted every two weeks for one month, then quarterly.</p> <p>The DON will interview five staff members weekly for one month to ensure the employees are aware of how to determine if a resident is a full code or DNR and what actions should be taken dependent upon the resident's code status. Thereafter, the DON will audit five staff members monthly for three months to ensure the staff is aware of the process for a full code and/or a DNR situation, then as determined by the Quality Assurance Committee.</p>		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702	
(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 490	<p>Continued From page 23 involving resident #1 was being investigated.</p> <p>An interview was conducted on March 3, 2011, at 11:00 a.m., with the Administrator, who stated although he/she was made aware on February 6, 2011, that resident #1 had expired at the facility without being administered CPR despite the resident being a "full code," all clinical issues in the facility were handled by the facility's Director of Nursing (DON). The Administrator explained that after ensuring the DON was made aware of the situation, the incident was primarily investigated and addressed by the DON.</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on March 8, 2011, which alleged removal of Immediate Jeopardy effective March 4, 2011. A partial extended survey was conducted on March 7-8, 2011, which determined the Immediate Jeopardy was removed on March 5, 2011.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>Resident #1 expired at the facility on February 6, 2011. On February 7, 2011, all current residents' charts were audited by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Coordinators (UC) for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) forms to ensure the forms were signed by the resident, Power of Attorney (POA), or Guardian as applicable. All charts were verified to contain the correct code status for the resident.</p> <p>The Code Status Policy was reviewed and</p>	F 490	<p>The Director of Nursing or ADON will audit all new admissions and 4 other charts for code status, physician's orders, and Emergency Medical System (EMS) Do Not Resuscitate (DNR) to determine the residents code status is appropriately documented and to ensure the forms were signed by the resident, Power of Attorney (POA), or Guardian as applicable weekly for three months, monthly for three months, then as determined by the QA Committee.</p> <p>The Medical records clerk will audit all charts monthly for three months to determine if the charts contain the physicians order and is clearly labeled with the correct code status.</p> <p>The Administrator will interview five residents weekly to determine if there have been any instances of perceived abuse or neglect. The administrator will also interview five staff members weekly in an effort to monitor for instances of perceived neglect/abuse in cognitively impaired residents for the next three months, then as directed by the Quality Assurance Committee. The DON, ADON and/or UC will visually audit nine residents weekly for three months to ensure that there are no indications of abuse / neglect, then as directed by the Quality Assurance Committee.</p> <p>The Administrator will review the audit findings and report to the Quality Assurance Committee monthly. The monthly QA Committee findings will be reviewed by the Medical Director at the quarterly QA Committee meeting to evaluate the effectiveness of the actions taken.</p>	3/31/11

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 490	<p>Continued From page 24</p> <p>revised by the Administrator and DON on February 7, 2011. Current CPR Certification was validated for all licensed nurses on February 7, 2011, and subsequent renewal classes were held on February 16 and 17, 2011.</p> <p>RN #1 received individual in-servicing on February 7, 2011, on the revised code policy and procedure.</p> <p>All Nursing staff was educated on February 7, 2011, by the Staff Development Coordinator (SDC) on the revised Code Policy.</p> <p>New employees will be in-serviced while in orientation related to the guidelines for determining if a resident is a full code and how to promptly identify each resident's code status and what actions to take if the resident is a full code or DNR.</p> <p>Ongoing in-servicing related to guidelines for determining if a resident is a full code and how to promptly identify each resident's code status and what actions to take if the resident is a full code or DNR will be conducted by the SDC monthly for three months and then as directed by the Quality Assurance (QA) Committee.</p> <p>The Medical Director was consulted and reviewed the Revised Code Status Policy and Procedure on March 3, 2011.</p> <p>The DON will interview five staff members weekly for one month to ensure the employees are aware of how to determine if a resident is a full code or a DNR and what action should be taken dependent upon the resident's code status. Additionally, the DON, ADON, and UC will conduct a mock code</p>	F 490			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 490	<p>Continued From page 25</p> <p>weekly for one month on diverse shifts to ensure that staff follows the facility's Revised Code Status policy and procedure. Thereafter, the mock codes will be conducted every two weeks for one month, and then conducted quarterly.</p> <p>The DON will audit all new admissions and four additional charts weekly to determine the resident's appropriate code status is clearly documented and all forms are contained in the resident's medical record. The medical records clerk will audit all charts monthly for three months to determine if the medical record contains physician's orders and is clearly labeled with the correct code status.</p> <p>The Abuse and Neglect Policy and Procedure was reviewed by the Administrator and DON on March 2, 2011. Education/training related to abuse/neglect prevention and reporting was conducted for all employees on March 2-4, 2011, by the Staff Development Coordinator (SDC), DON, ADON, UCs, and Administrator.</p> <p>The Administrator and DON were re-educated regarding their responsibilities to report suspected abuse/neglect when identified by the SDC on March 2, 2011.</p> <p>New employees will be in-serviced related to abuse/neglect prevention and reporting while in orientation.</p> <p>Ongoing in-servicing related to abuse and neglect prevention/reporting will be provided to nursing staff by the SDC monthly for three months then as directed by the Quality Assurance (QA) Committee.</p>	F 490			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702	
(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 490	<p>Continued From page 26</p> <p>The Administrator will interview five residents and five staff members weekly to determine if any perceived instances of abuse/neglect have occurred. The DON, ADON, and/or UC will visually audit nine residents weekly for three months to ensure there are no indications of abuse/neglect. The Administrator will review the audits with the QA committee, who will direct continued visual audits.</p> <p>The surveyor validated the corrective action taken by the facility as follows:</p> <p>Review of Code Status Review forms dated February 7, 2011, and interviews conducted on March 8, 2011, with the DON, ADON, and UC revealed all resident charts were audited for correct code status, appropriate physician's orders, and signed EMS forms on February 7, 2011. Additionally, a review of five resident charts on March 7, 2011, revealed the charts were designated with the appropriate code status, contained physician's orders, and contained a signed EMS form.</p> <p>Review of the revised Code policy and procedure including the Full Code Status versus No Code-DNR revision dated February 7, 2011, revealed the policy and procedure contained specifics regarding decisions of code status by the resident/family, what must be documented in the medical record, what designation of a "full code" entailed, and specific instructions for staff to utilize when a resident was found unresponsive to ensure the resident's correct code status was initiated. Additionally, a review of Current and Expiration of CPR Certification and interview with the DON on March 8, 2011, revealed that a review of all licensed staff's CPR certification was</p>	F 490		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 490	<p>Continued From page 27</p> <p>conducted and as of February 17, 2011, all licensed staff was certified in CPR.</p> <p>Review of a Counseling/Discipline Record for RN #1 dated February 25, 2011, and interview with RN #1 on March 2, 2011, revealed RN #1 was educated regarding the revised code status policy/procedure on February 7, 2011.</p> <p>Review of Upstairs Solutions DNR/No Code Policy and Procedure training dated February 7, 2011, and interview with the SDC on March 8, 2011, revealed nursing staff had been in-serviced regarding the revised Code Policy. Additionally, interviews on March 2-8, 2011, with RN #2, Licensed Practical Nurse (LPN) #2, LPN #3, Certified Nursing Assistants (CNAs) #1, #2, and #3, and a Certified Medication Technician (CMT) revealed staff had received training regarding the Revised Code Policy on February 7, 2011.</p> <p>Review of a facility Orientation Checklist and interview with the DON on March 8, 2011, revealed new employees would be trained regarding the facility's revised CPR policy and CPR Certification during facility orientation.</p> <p>Interview with the DON on March 8, 2011, revealed the facility had scheduled training regarding the facility's revised CPR policy and procedure for March, April, and May 2011.</p> <p>Review of the Revised Code Status Policy and Procedure revealed the Medical Director's signature verifying review and approval of the document on March 3, 2011.</p> <p>Review of QA Mock Full Code Status forms and interview with the DON on March 8, 2011,</p>	F 490		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 490	<p>Continued From page 28</p> <p>revealed staff was able to answer the mock code questions appropriately on March 3, 2011, and appropriately performed a Mock code simulation on March 7, 2011. Additionally, interviews conducted on March 2-8, 2011, with RN #1, RN #2, LPN #2, LPN #3, LPN #4, LPN #6, CNA #1, CNA #2, CNA #3, CMT #1, and LPN #5 revealed staff was knowledgeable and able to verbalize all parts/steps in the facility's Revised Code Status in regards to acting appropriately in a code situation.</p> <p>Review of a QA Code Status dated March 2, 2011, and interview with the DON on March 8, 2011, revealed ten resident charts were reviewed with no concerns identified related to appropriate physician's orders and labeling of the chart in regard to code status. Additionally, a review of five resident charts on March 7, 2011, revealed the charts were designated with the appropriate code status, and contained physician's orders for the appropriate code status.</p> <p>Interviews with the Administrator and DON on March 8, 2011, revealed the review of the abuse and neglect policy and procedure conducted on March 2, 2011, revealed no identified concerns. Additionally, a copy of the Abuse Reporting and Prevention policy/procedure signed and dated March 2, 2011, by the Administrator and DON was reviewed.</p> <p>Review of On the Spot Education/Re-education forms dated March 2, 3, and 4, 2011, and interviews with the SDC, DON, ADON, UCs, and Administrator on March 8, 2011, revealed staff had been in-serviced, including RN #1, regarding the abuse/neglect policy and procedure. Additionally, interviews on March 7-8, 2011, with RN #2, LPN #3, CNAs #1, #2, and #3, and the</p>	F 490			

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 490	<p>Continued From page 29</p> <p>CMT on March 8, 2011, revealed all the staff interviewed had attended training on the abuse neglect policy/procedure on either March 2, 3, or 4, 2011.</p> <p>Review of an On the Spot Education/Re-education dated March 2, 2011, and interviews with the Administrator and DON on March 8, 2011, revealed the SDC had re-educated the Administrator and DON of their ultimate responsibility to report allegations of abuse and neglect to the appropriate agencies timely.</p> <p>Review of a facility's Orientation Checklist and interview with the DON on March 8, 2011, revealed new employees would be trained regarding the facility's abuse/neglect policy/procedure including prevention and reporting during the facility orientation.</p> <p>Review of a Monthly Education form and interview with the DON on March 8, 2011, revealed the facility had scheduled abuse/neglect training for March, April, and May 2011.</p> <p>Review of QA Audits: Perceived Neglect or Abuse Allegations dated March 4, 2011, and signed by the Administrator, and interview with the Administrator on March 8, 2011, revealed five residents and five staff persons were interviewed regarding any perceived abuse or neglect incidents with no concerns identified. Additionally, a review of Quality Assurance: Round Audit Tools dated March 4, 2011, and interviews with the DON, ADON, and UC on March 8, 2011, revealed nine residents were reviewed on March 4, 2011, for any signs/symptoms of neglect with no concerns</p>	F 490		

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

PRINTED: 03/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
(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 490	Continued From page 30 identified. Based on the above findings, it was determined the Immediate Jeopardy was removed on March 5, 2011. Noncompliance continued with scope and severity lowered to "D" based on the facility's need to evaluate the effectiveness of Quality Assurance activities related to the implementation of policies and procedures for ensuring residents were free from abuse/neglect and ensuring the facility provided the necessary care and services to maintain each resident's physical wellbeing.	F 490			