

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

PRINTED: 06/10/2013  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/24/2013
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1800 WESTEN AVENUE BOWLING GREEN, KY 42104	
(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  A recertification survey was conducted 05/22/13 through 05/24/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "D".	F 000		6/19/13
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  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 promote care in a manner that maintains dignity and privacy during provision of care for one resident (#3), in the selected sample of ten residents.  Findings Include:  Review of the facility's policy/procedure, Privacy and Dignity, dated 02/2011, revealed "It is the policy of this facility to provide general guidelines for resident rights while caring for the resident. The policy/procedure further revealed "Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including resident dignity and respect. For any procedure that involves direct resident care, follow these steps: Close the room	F 241		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
<i>Heather Kenyon</i>		Administrator		7/10/13

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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F 241	<p>Continued From page 1 entrance door and provide for the resident's privacy."</p> <p>A record review revealed the facility admitted Resident #3 on 04/11/13 with diagnoses to include Congestive Heart Failure, Epistaxis, Atrial-Fibrillation, Coronary Artery Disease, Hypertension, Alzheimer's/Dementia, Dementia with Behavior, Abnormal Gait, Lack of Coordination, Muscle Weakness, Dysphagia, Symbolic Dysfunction. A Review of the Admission Minimum Data Set (MDS), dated 04/23/13, revealed a Brief Interview for Mental Status (BIMS) of two (2), which indicated the resident was severely cognitively impaired.</p> <p>A review of the care plan "Self-Care Deficit related to inability to complete ADLs safely", dated 04/25/13, revealed the resident was to be provided privacy, and dignity was to be promoted.</p> <p>Observation, on 05/22/13 at 3:15 PM, revealed while providing peri care and incontinent care for Resident #3, Certified Nurse Aide (CNA) #1 and CNA #2 did not close the privacy curtain, and left the door to the hallway open. This left the resident uncovered and exposed as others passed by in the hallway.</p> <p>Interview with CNA #1 and CNA #2, on 05/22/13 at 3:35 PM, revealed they did not pull the curtain while providing care to Resident #3, and they should have covered Resident #3 as much as possible during the provision of care.</p> <p>Interview with CNA #3, on 05/24/13 at 8:55 AM, revealed CNAs were trained to knock before going into a resident's room, to pull the privacy</p>	F 241	<p>privacy. This inservice was done on 6/10/13. All residents were interviewed by the Social Service Director on 6/18/13 in order to assure that no other residents were affected by this deficient practice.</p> <p>3. A Providing for Privacy Audit was initiated on 6/18/13. This audit will be completed by the Staff Development Coordinator and will review 10% of all residents on a weekly basis for the next four weeks. These audits will then be submitted weekly to the Director of Nursing for review.</p> <p>4. The Providing for Privacy Audit will be completed weekly for the next month and then continue monthly for the next six months. These will be reviewed by the</p>		

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F 241	Continued From page 2 curtains, to pull the window curtains/blinds, and to make sure the resident was covered, and privacy ensured while providing care.  Interview with Licensed Practical Nurse (LPN) #1, on 05/22/13 at 3:40 PM, revealed CNAs were suppose to pull the privacy curtain during the provision of care for every resident.  Interview with Registered Nurse (RN) #1, on 05/22/13 at 3:45 PM, revealed complete privacy was to be provided during the provision of care, and residents needed to be isolated from windows, doors, hallway and roommates when care was provided. The care plan should be followed and the staff should use an extra blanket to cover him/her up during care.  Interview with the Director of Nursing (DON), on 05/23/13 at 2:50 PM, revealed she expected interventions to be on the care plans and followed, such as ensuring privacy/dignity was provided for each resident.	F 241	Administrator monthly and forwarded to the monthly QA committee for review and recommendations for changes. A Dignity and Privacy Audit will continue quarterly thereafter by the Administrator or designee; this will be reviewed by the QA committee.	
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, interviews and record reviews it was determined the facility failed to ensure medications were administered as per the Physician's Order for one resident (#11), not in	F 281	F281 1. Resident No. 1 had no ill effects from this alleged deficiency. A medication error form was completed on 5/23/13 by the charge nurse. The physician was notified on 5/23/13 with orders to give Resident No. 1 the last dose of antibiotic.  2. All residents have the potential to be affected by	6/19/13

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F 281	<p>Continued From page 3</p> <p>the selected sample of ten. Observation of a medication pass on 05/23/13 revealed Resident #11 did not receive a prescribed medication.</p> <p>Findings include:</p> <p>Review of the facility policy, titled "Patient Care Orders, Implementation OP" and dated 12/98, revealed documentation to include "In the receipt and implementation of orders, nurses should follow written approved policies and procedures of the health care facility which are consistent with Karsa Chapter 314".</p> <p>Resident #11 was admitted to the facility with diagnoses to include Congestive Heart Failure, Disease of the Lung and Obstructive Sleep Apnea.</p> <p>Review of a Physician's Order, dated 05/13/13 at 8:20 AM, revealed Macrobid 100 milligrams (mg) by mouth two times a day for ten days.</p> <p>An observation of a medication pass on 05/23/13 at 8:20 AM, revealed Licensed Practical Nurse (LPN) #2 administering Resident #11's medications. Comparison of the medications administered to Resident #11 and the Resident's Physician's Orders revealed Resident #11 did not receive the last prescribed dose of Macrobid 100 mg.</p> <p>Review of the Medication Administration Record (MAR) revealed Resident #11 was to receive the final morning dose of Macrobid on 05/23/13. The MAR did not have an initial in the 05/23/13 for 8:00 AM dose indicating the medication had not been administered.</p>	F 281	<p>this deficient practice. On 6/17/13 the Director of Nursing reviewed all residents physician medication orders in comparison to the Medication Administration Record to assure accuracy, this was including but not limited to stop dates on antibiotics. No other residents were affected.</p> <p>3. An inservice was completed by the Director of Nursing on 6/18/13 with all licensed staff. The inservice included following physician orders, transcribing orders to the Medication Administration Record, and administering medications as prescribed by the physician.</p> <p>4. Beginning on 6/17/13, the Director of Nursing or designee will audit the Medication Administration Record daily (Monday through Friday) to ensure medication is administered</p>	

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F 281	Continued From page 4  An interview with LPN #2 on 05/23/13 at 10:15 AM revealed she read the MAR incorrectly and Resident #11 was to have been administered a dose of Macrobid 100 mg at 8:00 AM and she just missed it.  An interview with the Director of Nursing (DON) on 05/23/13 at 2:00 PM, revealed she expected nurses to follow Physician's Orders and administer medications as prescribed.	F 281	per physician orders. These audits will be completed daily for the next month and weekly for the next six months. Audits will be forwarded to the Administrator for review, as well as submitted to the monthly QA committee for review and recommendations for changes.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews, and facility policy it was determined the facility failed to ensure care plan interventions were implemented related to derma sleeves, low bed and a functional alarm for one resident (Resident #3) in the sample size of ten (10).  Findings Include:  Review of the undated facility policy entitled, Care Plan, revealed; "It is the policy of this facility that all residents will have care plans. The resident's care plan provides guidance to all staff caring for the resident and communicates changes in care	F 282	F282 1. Resident No. 3 had no ill effects from this alleged deficiency. The derma sleeves were put on Resident No. 3 immediately following observation on 5/24/13. CNA No. 3 was coached by the Staff Development Coordinator on 5/24/13. Following the observation on 5/22/13, the alarm box was connected and functioning properly. CNA No. 1 and No. 2 were coached by the Staff	6/20/13	

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F 282	<p>Continued From page 5</p> <p>to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care".</p> <p>Review of Facility Policy entitled, Falls Prevention with effective date of 02/2011, revealed "It is the policy of this facility through assessment and intervention to provide supervision and assistance to residents in an effort to avoid falls and minimize injury that may result from a resident falling. Residents identified as being at risk for falls will have a falls care plan initiated based on individual risk factors. The charge nurse will complete an Incident/Accident Investigation to determine the root cause of the fall. Based on the findings a new intervention will be added to aid in avoiding future falls. The Director of Nursing or designee will review the care plan to ensure it has been updated to reflect the proper intervention initiated".</p> <p>Record Review revealed Resident #3 was admitted to the facility on 04/11/13 with diagnoses to include Congestive Heart Failure, Epistaxis, Atrial-Fibrillation, Coronary Artery Disease, Hypertension, Alzheimer's/Dementia, Dementia with Behavior, Abnormal Gait, Lack of Coordination, Muscle Weakness, Dysphagia, Symbolic Dysfunction. A Review of the Admission Minimum Data Set dated 04/23/13, revealed the facility assessed Resident #3 with severe cognitive impairment.</p> <p>Review of Certified Nursing Assistant (CNA) care plan dated 05/2013, revealed that Resident #3</p>	F 282	<p>Development Coordinator on 5/24/13 for not following the plan of care. The low bed was assessed by the Director of Nursing on 5/23/13 and was in working order.</p> <p>2. On 6/19/13 an audit was completed by the Director of Nursing, Staff Development Coordinator, and MDS Coordinator to ensure that services provided or arranged by the facility were in accordance with each residents' plan of care and nurse aide care plans.</p> <p>3. An inservice was conducted on 6/10/13 by the Staff Development Coordinator with all nursing staff (CNA, CMT, LPN, and RN) reviewing that services provided must follow the resident's plan of care.</p>		

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F 282	<p>Continued From page 6</p> <p>was to have derma sleeves to bilateral upper extremities and bilateral lower extremities, a bed sensor alarm and low bed.</p> <p>Record Review of Fall Care Plan and Potential Pressure Ulcer/Impairment of Skin Integrity Care Plan dated 04/25/13 for Resident #3 revealed he/she was to have a bed sensor alarm, bed in lowest position and bilateral upper and lower derma sleeves.</p> <p>Record Review of Physician's Orders dated 05/04/13 revealed Resident #3 was to have derma sleeves to upper and lower extremities.</p> <p>Observation and interview on 05/24/13 at 10:15 AM, revealed the DON verified Resident #3 did not have on derma sleeves. The DON reviewed and verified the Potential Pressure Ulcer/Impairment of skin integrity care plan dated 4/25/13 and the CNA care plan dated 5/13 which stated Resident #3 was to have them on bilaterally.</p> <p>Interview on 05/24/13 at 10:45 AM, with CNA #3 revealed she had forgotten to put the derma sleeves on Resident #3 arms. She did look at the care plan and she had been inserviced to follow the care plan when taking care of the residents.</p> <p>Observation on 05/22/13 at 10:25 AM, revealed the bed alarm cord not connected to the alarm box and the bed was not in the low position.</p> <p>Observation on 05/22/13 at 3:15 PM, with CNA s #1 and #2 revealed after providing incontinent care to Resident #3 the bed alarm cord was not connected to the alarm box and the bed was not</p>	F 282	<p>4. Care Plan Intervention Audits will be performed weekly by the Director of Nursing or designee for the next month. The Care Plan Intervention Audit will then be conducted monthly thereafter for the next four months. These audits will be submitted to the Administrator for review and then forwarded to the monthly QA committee for further review and recommendations for changes.</p>		

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F 282	<p>Continued From page 7</p> <p>in the lowest position when CNA #1 and CNA #2's left Resident #3's room with the resident in the bed.</p> <p>Interview and observation on 05/22/13 at 3:35 PM, with CNAs #1 and #2 revealed they should have made sure the alarm cord was plugged to the alarm box. CNA #1 and CNA #2 looked for the crank for the bed and stated that they couldn't find a way to lower the bed and left Resident #3's room.</p> <p>Interview on 05/22/13 at 3:40, with Licensed Practical Nurse (LPN) #1 revealed when a resident is in bed CNAs should make sure the bed alarm is in place and working before leaving the room and the aides couldn't lower the bed because they couldn't find the crank to the bed.</p> <p>Interview on 05/22/13 at 3:45 PM, with Registered Nurse (RN) #1 revealed he expected the CNAs to follow care plan and to check the alarm to make sure that it is working and in place and functioning properly.</p> <p>Interview on 05/23/13 at 2:50 PM, with the DON revealed she expected interventions to be on the care plan and the interventions followed for Resident #3.</p> <p>Interview on 05/24/13 at 10:20 AM, with the Staff Development Coordinator/Case Manager (SDC) revealed the CDNAs were to go by the CNA care plan at all times. He updated the care plan when an issue was identified, such as low beds and bed alarms. The SDC further stated while the resident was in the bed it should be in the lowest position possible. If residents have alarms, the</p>	F 282			

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F 282	Continued From page 8 alarm was to be on at all times except when resident is showering or toileting. The SDC then stated the CNAs were inserviced on how to lower beds, and if they did not know how to lower the bed they were to go to their immediate supervisor, DON, or himself.	F 282			
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.  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews and facility policy, it was determined the facility failed to ensure a safe environment related to care plan interventions not implemented for safety for one resident (Resident #3) in a sample size of ten (10). Resident #3 was observed in bed with the bed not in the low position and the resident's safety alarm not connected.  Findings Include:  Review of the facility policy entitled, Falls Prevention with effective date of 02/2011, revealed the following: "It is the policy of this facility through assessment and intervention to	F 323	F323 1. Resident No. 3 had no ill effects. The derma sleeves were put on Resident No. 3 immediately following observation on 5/24/13. CNA No. 3 was coached by the Staff Development Coordinator on 5/24/13. Following the observation on 5/22/13, the alarm box was connected and functioning properly. CNA No. 1 and No. 2 were coached by the Staff Development Coordinator on 5/24/13 for not following the plan of care. The low bed was assessed by the Director of Nursing on 5/23/13 and was in working order.	6/19/13	

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F 323	<p>Continued From page 9</p> <p>provide supervision and assistance to residents in an effort to avoid falls and minimize injury that may result from a resident falling. The procedure portion of the policy stated "Residents identified as being at risk for falls will have a falls care plan initiated based on individual risk factors. The charge nurse will complete an Incident/Accident Investigation to determine the root cause of the fall. Based on the findings a new intervention will be added to aid in avoiding future falls. The Director of nursing or designee will review the care plan to ensure it has been updated to reflect the proper intervention initiated".</p> <p>Review of the undated facility policy entitled, Care Plan, revealed "It is the policy of this facility that all residents will have care plans. The resident's care plan provides guidance to all staff caring for the resident and communicates changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care".</p> <p>Resident #3 was admitted to the facility on 04/11/13 with diagnoses to include Congestive Heart Failure, Epistaxis, Atrial-Fibrillation, Coronary Artery Disease, Hypertension, Alzheimer's/Dementia, Dementia with Behavior, Abnormal Gait, Lack of Coordination, Muscle Weakness, Dysphagia, Symbolic Dysfunction. The admission Minimum Data Set dated 04/23/13, revealed a the facility had assessed Resident with cognitive impairment and required extensive assistance with activities of daily living.</p> <p>Review of the Certified Nursing Assistant (CNA)</p>	F 323	<p>2. An audit on all beds and alarm devices was performed to ensure proper functioning. This was done by maintenance and medical records personnel on 6/18/13.</p> <p>3. An inserview with all nursing staff was conducted on 6/10/13 by the Staff Development Coordinator reviewing keeping residents free of accident hazards as is possible.</p> <p>4. Alarm audits will be conducted weekly by medical records personnel for the next three months. The alarm audits will continue monthly thereafter. Bed audits will be completed weekly by maintenance staff for the next month and then monthly thereafter for the next six months. Both the alarm and bed audits will be submitted to the</p>		

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F 323	<p>Continued From page 10</p> <p>care plan dated 05/2013, revealed Resident #3 was to have a bed sensor alarm and the bed in low position.</p> <p>Review of resident #3's Fall care plan, dated 04/25/13, revealed Resident #3 was supposed to have a bed sensor alarm and bed in lowest position.</p> <p>An observation on 05/22/13 at 10:25 AM, revealed the bed alarm cord to be in the floor underneath the bed and not connected to the alarm box and the bed position not in the lowest position.</p> <p>Observation on 05/22/13 at 3:15 PM, with CNAs #1 and #2, revealed after providing incontinent care to Resident #3, the bed alarm cord was underneath the bed and not connected to the alarm box and the bed was not in the lowest position when the CNA #1 and CNA #2 left from Resident #3's room with the resident in the bed.</p> <p>Interview and observation on 05/22/13 at 3:35 PM, with CNAs #1 and CNA #2 revealed they should have made sure the resident's alarm was on and plugged the alarm cord to the alarm box. CNA #1 and CNA #2 looked for the crank for the bed and stated that they couldn't find a way to lower the bed and left Resident #3's room with the resident lying in the bed with the bed not in the lowest positron.</p> <p>An interview on 05/22/13 at 3:40 PM, with Licensed Practical Nurse (LPN) #1 revealed when a resident was in the bed, CNAs should make sure the bed alarm is in place and functioning before leaving the room, and the</p>	F 323	Administrator and will then be forwarded to the monthly QA committee for review and recommendations for changes.		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185419</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/24/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1800 WESTEN AVENUE BOWLING GREEN, KY 42104</b>		
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F 323	<p>Continued From page 11</p> <p>aides couldn't lower the bed because they were unable to find the crank to the bed.</p> <p>Interview on 05/22/13 at 3:45 PM, with Registered Nurse (RN) #1 revealed he expected CNAs to follow care plans, to check alarms and make sure they are in place, and functioning properly.</p> <p>Observation on 05/22/13 at 3:50 PM, revealed Resident #3's bed was not in the lowest position.</p> <p>Interview on 05/23/13 at 2:50 PM, with the DON revealed she expected interventions to be on resident #3's care plans and to be followed.</p> <p>Interview on 05/24/13 at 10:20 AM, with Staff Development Coordinator/Case Manager (SDC) revealed the CNAs were to go by the CNA care plan at all times and that he updated the care plan when issues arise, such as low beds and bed alarms. The SDC further stated while the resident was in the bed it should be in the lowest position possible. The alarm was to be on at all times except when showering or toileting. The SDC additionally stated the CNAs were inserviced on how to lower beds and if they did not know how to lower the bed they were to go to their immediate supervisor, DON, or come to the SDC.</p> <p>Interview with LPN #3 on 05/24/13 at 8:45 AM, revealed Resident #3's bed was not in the lowest position and should be when the resident was in the bed. LPN #3 further stated that all CNAs were inserviced about the function of the beds.</p> <p>Interview on 05/24/13 at 8:55 AM, with CNA #3 revealed CNAs were inserviced on how to raise</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>and lower the beds and if a resident was care planned for a low bed they needed to make sure it is in the lowest position. CNA #3 further stated they were trained to know if alarms were functioning by testing the alarm for the beep, if it was working, to make sure the light blinks to indicate it was turned on. When the resident was in the bed they were to make sure cord of the alarm was plugged into the alarm box.</p> <p>An interview the the DON on 05/24/13 at 9:05 AM, revealed the bed was not in the lowest position and CNAs were trained to know how to lower the beds. She stated, if a resident was care planned to be on a low bed, the bed should be in the lowest position possible when the resident was in the bed. The DON further stated that if the CNAs did not know how to lower a bed they should get their charge nurse or someone to show them how to lower it, and she expected the interventions on a care plan to be followed.</p> <p>On 05/24/13 at 1:57 PM, an interview with CNA #1 revealed Resident #3 was supposed to be on a low bed, and she couldn't figure out how to lower it. CNA #1 further revealed she should have looked for at the CNA care plan for Resident #3 for guidance, and had someone stay with the resident until she could get the bed adjusted or get someone to fix it. She additionally stated not ensuring the bed was in the lowest position put the resident at risk for injury if there was a fall.</p>	F 323			



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N 113	<p>Continued From page 1</p> <p>include Congestive Heart Failure, Epistaxis, Atrial-Fibrillation, Coronary Artery Disease, Hypertension, Alzheimer's/Dementia, Dementia with Behavior, Abnormal Gait, Lack of Coordination, Muscle Weakness, Dysphagia, Symbolic Dysfunction. A Review of the Admission Minimum Data Set (MDS), dated 04/23/13, revealed a Brief Interview for Mental Status (BIMS) of two (2), which indicated the resident was severely cognitively impaired.</p> <p>A review of the care plan "Self-Care Deficit related to inability to complete ADLs safely", dated 04/25/13, revealed the resident was to be provided privacy, and dignity was to be promoted.</p> <p>Observation, on 05/22/13 at 3:15 PM, revealed while providing peri care and incontinent care for Resident #3, Certified Nurse Aide (CNA) #1 and CNA #2 did not close the privacy curtain, and left the door to the hallway open. This left the resident uncovered and exposed as others passed by in the hallway.</p> <p>Interview with CNA #1 and CNA #2, on 05/22/13 at 3:35 PM, revealed they did not pull the curtain while providing care to Resident #3, and they should have covered Resident #3 as much as possible during the provision of care.</p> <p>Interview with CNA #3, on 05/24/13 at 8:55 AM, revealed CNAs were trained to knock before going into a resident's room, to pull the privacy curtains, to pull the window curtains/blinds, and to make sure the resident was covered, and privacy ensured while providing care.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/22/13 at 3:40 PM, revealed CNAs were suppose to pull the privacy curtain during the</p>	N 113	<p>residents were interviewed by the Social Service Director on 6/18/13 in order to assure that no other residents were affected by this deficient practice.</p> <p>3. A Providing for Privacy Audit was initiated on 6/18/13. This audit will be completed by the Staff Development Coordinator and will review 10% of all residents on a weekly basis for the next four weeks. These audits will then be submitted weekly to the Director of Nursing for review.</p> <p>4. The Providing for Privacy Audit will be completed weekly for the next month and then continue monthly for the next six months. These will be reviewed by the Administrator monthly and forwarded to the monthly QA committee for review and recommendations for</p>	

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N 113	Continued From page 2 provision of care for every resident.  Interview with Registered Nurse (RN) #1, on 05/22/13 at 3:45 PM, revealed complete privacy was to be provided during the provision of care, and residents needed to be isolated from windows, doors, hallway and roommates when care was provided. The care plan should be followed and the staff should use an extra blanket to cover him/her up during care.  Interview with the Director of Nursing (DON), on 05/23/13 at 2:50 PM, revealed she expected interventions to be on the care plans and followed, such as ensuring privacy/dignity was provided for each resident.	N 113	changes. A Dignity and Privacy Audit will continue quarterly thereafter by the Administrator or designee; this will be reviewed by the QA committee.	
N 193	902 KAR 20:300-7(4)(c)1. Section 7. Resident Assessment  (4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 1. Meet professional standards of quality; and  This requirement is not met as evidenced by: Based on observation, interviews and record reviews it was determined the facility failed to ensure medications were administered as per the Physician's Order for one resident (#11), not in the selected sample of ten. Observation of a medication pass on 05/23/13 revealed Resident #11 did not receive a prescribed medication.  Findings include:  Review of the facility policy, titled "Patient Care Orders, Implementation Of" and dated 12/98, revealed documentation to include "In the receipt	N 193	N193 1. Resident No. 1 had no ill effects from this alleged deficiency. A medication error form was completed on 5/23/13 by the charge nurse. The physician was notified on 5/23/13 with orders to give Resident No. 1 the last dose of antibiotic.  2. All residents have the potential to be affected by this deficient practice. On 6/17/13 the Director of Nursing reviewed all residents physician	6/19/13

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N 193	<p>Continued From page 3</p> <p>and implementation of orders, nurses should follow written approved policies and procedures of the health care facility which are consistent with Karsa Chapter 314".</p> <p>Resident #11 was admitted to the facility with diagnoses to include Congestive Heart Failure, Disease of the Lung and Obstructive Sleep Apnea.</p> <p>Review of a Physician's Order, dated 05/13/13 at 8:20 AM, revealed Macrobid 100 milligrams (mg) by mouth two times a day for ten days.</p> <p>An observation of a medication pass on 05/23/13 at 8:20 AM, revealed Licensed Practical Nurse (LPN) #2 administering Resident #11's medications. Comparison of the medications administered to Resident #11 and the Resident's Physician's Orders revealed Resident #11 did not receive the last prescribed dose of Macrobid 100 mg.</p> <p>Review of the Medication Administration Record (MAR) revealed Resident #11 was to receive the final morning dose of Macrobid on 05/23/13. The MAR did not have an initial in the 05/23/13 for 8:00 AM dose indicating the medication had not been administered.</p> <p>An interview with LPN #2 on 05/23/13 at 10:15 AM revealed she read the MAR incorrectly and Resident #11 was to have been administered a dose of Macrobid 100 mg at 8:00 AM and she just missed it.</p> <p>An interview with the Director of Nursing (DON) on 05/23/13 at 2:00 PM, revealed she expected nurses to follow Physician's Orders and administer medications as prescribed.</p>	N 193	<p>medication orders in comparison to the Medication Administration Record to assure accuracy, this was including but not limited to stop dates on antibiotics. No other residents were affected.</p> <p>3. An inservice was completed by the Director of Nursing on 6/18/13 with all licensed staff. The inservice included following physician orders, transcribing orders to the Medication Administration Record, and administering medications as prescribed by the physician.</p> <p>4. Beginning on 6/17/13, the Director of Nursing or designee will audit the Medication Administration Record daily (Monday through Friday) to ensure medication is administered per physician orders. These audits will be completed daily for the next month and weekly for</p>	

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N 194	<p>902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment</p> <p>(4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. Be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This requirement is not met as evidenced by: Based on observations, record reviews, interviews, and facility policy it was determined the facility failed to ensure care plan interventions were implemented related to derma sleeves, low bed and a functional alarm for one resident (Resident #3) in the sample size of ten (10).</p> <p>Findings Include:</p> <p>Review of the undated facility policy entitled, Care Plan, revealed; "It is the policy of this facility that all residents will have care plans. The resident's care plan provides guidance to all staff caring for the resident and communicates changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care".</p> <p>Review of Facility Policy entitled, Falls Prevention with effective date of 02/2011, revealed "It is the policy of this facility through assessment and intervention to provide supervision and assistance to residents in an effort to avoid falls and minimize injury that may result from a resident falling. Residents identified as being at risk for falls will have a falls care plan initiated based on individual risk factors. The charge nurse will complete an Incident/Accident</p>	N 194	<p>the next six months. Audits will be forwarded to the Administrator for review, as well as submitted to the monthly QA committee for review and recommendations for changes.</p> <p>N194 1. Resident No. 3 had no ill effects from this alleged deficiency. The derma sleeves were put on Resident No. 3 immediately following observation on 5/24/13. CNA No. 3 was coached by the Staff Development Coordinator on 5/24/13. Following the observation on 5/22/13, the alarm box was connected and functioning properly. CNA No. 1 and No. 2 were coached by the Staff Development Coordinator on 5/24/13 for not following the plan of care. The low bed was assessed</p>	6/20/13

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N 194	<p>Continued From page 5</p> <p>Investigation to determine the root cause of the fall. Based on the findings a new intervention will be added to aid in avoiding future falls. The Director of Nursing or designee will review the care plan to ensure it has been updated to reflect the proper intervention initiated".</p> <p>Record Review revealed Resident #3 was admitted to the facility on 04/11/13 with diagnoses to include Congestive Heart Failure, Epistaxis, Atrial-Fibrillation, Coronary Artery Disease, Hypertension, Alzheimer's/Dementia, Dementia with Behavior, Abnormal Gait, Lack of Coordination, Muscle Weakness, Dysphagia, Symbolic Dysfunction. A Review of the Admission Minimum Data Set dated 04/23/13, revealed the facility assessed Resident #3 with severe cognitive impairment.</p> <p>Review of Certified Nursing Assistant (CNA) care plan dated 05/2013, revealed that Resident #3 was to have derma sleeves to bilateral upper extremities and bilateral lower extremities, a bed sensor alarm and low bed.</p> <p>Record Review of Fall Care Plan and Potential Pressure Ulcer/Impairment of Skin Integrity Care Plan dated 04/25/13 for Resident #3 revealed he/she was to have a bed sensor alarm, bed in lowest position and bilateral upper and lower derma sleeves.</p> <p>Record Review of Physician's Orders dated 05/04/13 revealed Resident #3 was to have derma sleeves to upper and lower extremities.</p> <p>Observation and interview on 05/24/13 at 10:15 AM, revealed the DON verified Resident #3 did not have on derma sleeves. The DON reviewed</p>	N 194	<p>by the Director of Nursing on 5/23/13 and was in working order.</p> <p>2. On 6/19/13 an audit was completed by the Director of Nursing, Staff Development Coordinator, and MDS Coordinator to ensure that services provided or arranged by the facility were in accordance with each residents' plan of care and nurse aide care plans.</p> <p>3. An inservice was conducted on 6/10/13 by the Staff Development Coordinator with all nursing staff (CNA, CMT, LPN, and RN) reviewing that services provided must follow the resident's plan of care.</p> <p>4. Care Plan Intervention Audits will be performed weekly by the Director of Nursing or designee for the next month. The Care Plan Intervention Audit will</p>		

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N 194	<p>Continued From page 6</p> <p>and verified the Potential Pressure Ulcer/Impairment of skin integrity care plan dated 4/25/13 and the CNA care plan dated 5/13 which stated Resident #3 was to have them on bilaterally.</p> <p>Interview on 05/24/13 at 10:45 AM, with CNA #3 revealed she had forgotten to put the derma sleeves on Resident #3 arms. She did look at the care plan and she had been inserviced to follow the care plan when taking care of the residents.</p> <p>Observation on 05/22/13 at 10:25 AM, revealed the bed alarm cord not connected to the alarm box and the bed was not in the low position.</p> <p>Observation on 05/22/13 at 3:15 PM, with CNA s #1 and #2 revealed after providing incontinent care to Resident #3 the bed alarm cord was not connected to the alarm box and the bed was not in the lowest position when CNA #1 and CNA #2's left Resident #3's room with the resident in the bed.</p> <p>Interview and observation on 05/22/13 at 3:35 PM, with CNAs #1 and #2 revealed they should have made sure the alarm cord was plugged to the alarm box. CNA #1 and CNA #2 looked for the crank for the bed and stated that they couldn't find a way to lower the bed and left Resident #3's room.</p> <p>Interview on 05/22/13 at 3:40, with Licensed Practical Nurse (LPN) #1 revealed when a resident is in bed CNAs should make sure the bed alarm is in place and working before leaving the room and the aides couldn't lower the bed because they couldn't find the crank to the bed.</p> <p>Interview on 05/22/13 at 3:45 PM, with Registered</p>	N 194	<p>then be conducted monthly thereafter for the next four months. These audits will be submitted to the Administrator for review and then forwarded to the monthly QA committee for further review and recommendations for changes.</p>		

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N 194	Continued From page 7  Nurse (RN) #1 revealed he expected the CNAs to follow care plan and to check the alarm to make sure that it is working and in place and functioning properly.  Interview on 05/23/13 at 2:50 PM, with the DON revealed she expected interventions to be on the care plan and the interventions followed for Resident #3.  Interview on 05/24/13 at 10:20 AM, with the Staff Development Coordinator/Case Manager (SDC) revealed the CDNAs were to go by the CNA care plan at all times. He updated the care plan when an issue was identified, such as low beds and bed alarms. The SDC further stated while the resident was in the bed it should be in the lowest position possible. If residents have alarms, the alarm was to be on at all times except when resident is showering or toileting. The SDC then stated the CNAs were inserviced on how to lower beds, and if they did not know how to lower the bed they were to go to their immediate supervisor, DON, or himself.	N 194			
N 220	902 KAR 20:300-8(7)(b) Section 8. Quality of Care  (7) Accidents. The facility shall ensure that: (b) Each resident receives adequate supervision and assistive devices to prevent accidents.  This requirement is not met as evidenced by: Based on observations, record reviews, interviews and facility policy, it was determined the facility failed to ensure a safe environment	N 220	N220 1. Resident No. 3 had no ill effects. The derma sleeves were put on Resident No. 3 immediately following observation on 5/24/13. CNA No. 3 was coached by the Staff Development Coordinator on 5/24/13. Following the observation on 5/22/13, the alarm box	6/19/13	

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N 220	<p>Continued From page 8</p> <p>related to care plan interventions not implemented for safety for one resident (Resident #3) in a sample size of ten (10). Resident #3 was observed in bed with the bed not in the low position and the resident's safety alarm not connected.</p> <p>Findings Include:</p> <p>Review of the facility policy entitled, Falls Prevention with effective date of 02/2011, revealed the following: "It is the policy of this facility through assessment and intervention to provide supervision and assistance to residents in an effort to avoid falls and minimize injury that may result from a resident falling. The procedure portion of the policy stated "Residents identified as being at risk for falls will have a falls care plan initiated based on individual risk factors. The charge nurse will complete an Incident/Accident Investigation to determine the root cause of the fall. Based on the findings a new intervention will be added to aid in avoiding future falls. The Director of nursing or designee will review the care plan to ensure it has been updated to reflect the proper intervention initiated".</p> <p>Review of the undated facility policy entitled, Care Plan, revealed "It is the policy of this facility that all residents will have care plans. The resident's care plan provides guidance to all staff caring for the resident and communicates changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care".</p> <p>Resident #3 was admitted to the facility on 04/11/13 with diagnoses to include Congestive</p>	N 220	<p>was connected and functioning properly. CNA No. 1 and No. 2 were coached by the Staff Development Coordinator on 5/24/13 for not following the plan of care. The low bed was assessed by the Director of Nursing on 5/23/13 and was in working order.</p> <p>2. An audit on all beds and alarm devices was performed to ensure proper functioning. This was done by maintenance and medical records personnel on 6/18/13.</p> <p>3. An inserview with all nursing staff was conducted on 6/10/13 by the Staff Development Coordinator reviewing keeping residents free of accident hazards as is possible.</p> <p>4. Alarm audits will be conducted weekly by</p>		

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 WESTEN AVENUE BOWLING GREEN, KY 42104		
(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) COMPLETE DATE
N 220	<p>Continued From page 9</p> <p>Heart Failure, Epistaxis, Atrial-Fibrillation, Coronary Artery Disease, Hypertension, Alzheimer's/Dementia, Dementia with Behavior, Abnormal Gait, Lack of Coordination, Muscle Weakness, Dysphagia, Symbolic Dysfunction. The admission Minimum Data Set dated 04/23/13, revealed a the facility had assessed Resident with cognitive impairment and required extensive assistance with activities of daily living.</p> <p>Review of the Certified Nursing Assistant (CNA) care plan dated 05/2013, revealed Resident #3 was to have a bed sensor alarm and the bed in low position.</p> <p>Review of resident #3's Fall care plan, dated 04/25/13, revealed Resident #3 was supposed to have a bed sensor alarm and bed in lowest position.</p> <p>An observation on 05/22/13 at 10:25 AM, revealed the bed alarm cord to be in the floor underneath the bed and not connected to the alarm box and the bed position not in the lowest position.</p> <p>Observation on 05/22/13 at 3:15 PM, with CNAs #1 and #2, revealed after providing incontinent care to Resident #3, the bed alarm cord was underneath the bed and not connected to the alarm box and the bed was not in the lowest position when the CNA #1 and CNA #2 left from Resident #3's room with the resident in the bed.</p> <p>Interview and observation on 05/22/13 at 3:35 PM, with CNAs #1 and CNA #2 revealed they should have made sure the resident's alarm was on and plugged the alarm cord to the alarm box. CNA #1 and CNA #2 looked for the crank for the bed and stated that they couldn't find a way to</p>	N 220	<p>medical records personnel for the next three months. The alarm audits will continue monthly thereafter. Bed audits will be completed weekly by maintenance staff for the next month and then monthly thereafter for the next six months. Both the alarm and bed audits will be submitted to the Administrator and will then be forwarded to the monthly QA committee for review and recommendations for changes.</p>	

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N 220	<p>Continued From page 10</p> <p>lower the bed and left Resident #3's room with the resident lying in the bed with the bed not in the lowest positron.</p> <p>An interview on 05/22/13 at 3:40 PM, with Licensed Practical Nurse (LPN) #1 revealed when a resident was in the bed, CNAs should make sure the bed alarm is in place and functioning before leaving the room, and the aides couldn't lower the bed because they were unable to find the crank to the bed.</p> <p>Interview on 05/22/13 at 3:45 PM, with Registered Nurse (RN) #1 revealed he expected CNAs to follow care plans, to check alarms and make sure they are in place, and functioning properly.</p> <p>Observation on 05/22/13 at 3:50 PM, revealed Resident #3's bed was not in the lowest position.</p> <p>Interview on 05/23/13 at 2:50 PM, with the DON revealed she expected interventions to be on resident #3's care plans and to be followed.</p> <p>Interview on 05/24/13 at 10:20 AM, with Staff Development Coordinator/Case Manager (SDC) revealed the CNAs were to go by the CNA care plan at all times and that he updated the care plan when issues arise, such as low beds and bed alarms. The SDC further stated while the resident was in the bed it should be in the lowest position possible. The alarm was to be on at all times except when showering or toileting. The SDC additionally stated the CNAs were inserviced on how to lower beds and if they did not know how to lower the bed they were to go to their immediate supervisor, DON, or come to the SDC.</p> <p>Interview with LPN #3 on 05/24/13 at 8:45 AM,</p>	N 220		

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N 220	<p>Continued From page 11</p> <p>revealed Resident #3's bed was not in the lowest position and should be when the resident was in the bed. LPN #3 further stated that all CNAs were inserviced about the function of the beds.</p> <p>Interview on 05/24/13 at 8:55 AM, with CNA #3 revealed CNAs were inserviced on how to raise and lower the beds and if a resident was care planned for a low bed they needed to make sure it is in the lowest position. CNA #3 further stated they were trained to know if alarms were functioning by testing the alarm for the beep, if it was working, to make sure the light blinks to indicate it was turned on. When the resident was in the bed they were to make sure cord of the alarm was plugged into the alarm box.</p> <p>An interview the the DON on 05/24/13 at 9:05 AM, revealed the bed was not in the lowest position and CNAs were trained to know how to lower the beds. She stated, if a resident was care planned to be on a low bed, the bed should be in the lowest position possible when the resident was in the bed. The DON further stated that if the CNAs did not know how to lower a bed they should get their charge nurse or someone to show them how to lower it, and she expected the Interventions on a care plan to be followed.</p> <p>On 05/24/13 at 1:57 PM, an interview with CNA #1 revealed Resident #3 was supposed to be on a low bed, and she couldn't figure out how to lower it. CNA #1 further revealed she should have looked for at the CNA care plan for Resident #3 for guidance, and had someone stay with the resident until she could get the bed adjusted or get someone to fix it. She additionally stated not ensuring the bed was in the lowest position put the resident at risk for injury if there was a fall.</p>	N 220			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185419	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/23/2013
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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: 1995</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) stories, Type III (200)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 05/22/13 and concluded on 05/23/13. Christian Health Center of Bowling Green was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for twenty eight (28) beds with a census of twenty five (25) 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</p>	K 000		

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

*Heather Oberlin*

TITLE

*Administrator*

(X6) DATE

*7/10/13*

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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K 000	Continued From page 1 Fire)	K 000		
K 011 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire wall was in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff, and visitors. The facility is certified for twenty eight (28) beds with a census of twenty five (25) the day of the survey. The facility failed to ensure the fire doors in the two hour fire wall were rated for the wall.</p> <p>The findings include:</p> <p>Observation, on 05/23/13 at 8:00 AM, with the Housing Manager revealed the two hour wall separating the skilled nursing facility from the Independent living had doors and frame installed</p>	K 011	<p><b>K011</b></p> <p>1. No resident was affected by this alleged deficiency. The 300 Hall door and frame that connects the skilled nursing facility to the independent living will be replaced with a three (3) hour U.L. rated door and jamb. This is estimated to be completed on 6/28/13.</p> <p>2. All residents have the potential to be affected by this alleged deficiency. All other fire doors were inspected by the Housing Manager which was completed on 6/12/13.</p> <p>3. Fire rated door/exit doors were added to the Preventative Maintenance Program for a minimum of quarterly inspection completed on 6/12/13.</p>	6/29/13

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K 011	<p>Continued From page 2 that were rated for only one hour.</p> <p>Interview, on 05/23/13 at 8:00 AM, with the Housing Manager revealed he was unaware the doors were not rated properly for a two hour wall.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations. 19.1.1.4.1 Additions. Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.6.6.) 19.1.1.4.2 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.) 19.1.1.4.3 Doors in barriers required by 19.1.1.4.1 shall normally be kept closed. Exception: Doors shall be permitted to be held open if they meet the requirements of 19.2.2.2.6.</p> <p>8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance</p>	K 011	<p>Maintenance staff were inserviced by the Housing Manager on 6/13/13 on requirements of fire doors meeting two (2) hour fire wall when connecting to existing structure, and to ensure all doors are in good operating condition.</p> <p>4. Preventative Maintenance forms for fire doors will be completed monthly and presented to the Housing Manager upon completion. The Housing Manager will forward these to the Administrator. The Administrator will present these to QA on a monthly basis for the next six months for review and recommendations for changes.</p>	

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K 011	Continued From page 3 with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.	K 011			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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.  This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twenty eight (28) beds with a census of twenty five (25) on the day of the survey. The facility	K 050	K050 1. No resident was affected by this alleged deficiency. A fire drill schedule for 2013 was created by the Housing Manager and approved by the Administrator on 6/12/13. The fire drill schedule includes first, second, and third shift drills for each quarter at varying/unexpected times. This schedule will assist with drills being pre-planned and only known by the Housing Manager and Administrator.	6/15/13	

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K 050	<p>Continued From page 4</p> <p>failed to ensure the fire drills were conducted quarterly and at unexpected times on all shift.</p> <p>The findings include:</p> <p>Fire Drill review, on 05/22/13 at 2:19 PM, with Housing Manager revealed the facility failed to conduct fire drills at unexpected times on second (2nd) and third (3rd) shifts. Further observation revealed the facility failed to conduct a fire drill in the third quarter of 2012 on first shift. This is a repeat deficiency from a survey conducted in 2012.</p> <p>Interview, on 05/22/13 at 2:19 PM, with the Housing Manager revealed he was not aware the fire drills were not being conducted as required.</p> <p>Interview, on 05/23/13 at 8:55 AM, with the Administrator revealed she was not aware the fire drills were not being conducted as required.</p> <p>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 varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to</p>	K 050	<p>2. All residents have the potential to be affected by this deficient practice. The Housing Manager assured that a fire drill was conducted on all shifts for the last quarter; this was completed on 6/12/13.</p> <p>3. The fire drill schedule for 2013 was updated by the Housing Manager on 6/12/13. The fire alarm log will be reviewed monthly by the Housing Manager to assure all fire drills are completed per requirements. Maintenance staff were inserviced by the Housing Manager on requirements for quarterly fire drills on all shifts and at various times. This inservice was completed on 6/14/13.</p> <p>4. The Housing Manager will review and present the fire alarm log monthly for the next 6 months to the Administrator for review.</p>		

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K 050	Continued From page 5 all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	After review for compliance and completion, the Administrator will present to QA monthly for the next six months for further review and any recommendations for changes. The Housing Manager will report on the performed drills at QA and this will continue on an ongoing basis.		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the 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	K 056	K056 1. All identified sprinkler heads (101, 102, 107, 302, 305, 100 Hall corridor, foryer by nurses' station, 200 Hall restroom, DON office, 202 bathroom, 200 Hall by exit door, and 300 Hall by exit door) will be	7/9/13	

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K 056	<p>Continued From page 6</p> <p>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 installed, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twenty eight (28) beds with a census of twenty five (25) on the day of the survey. The facility failed to ensure the facility sprinkler heads were not blocked by light fixtures.</p> <p>The findings include:</p> <p>Observation, on 05/22/13 between 2:30 PM and 4:00 PM, Housing Manager revealed light fixtures installed within twelve (12 inches of a sprinkler head located in rooms 101, 102, 107, 30, 302, 305, 100 Hall corridor, foyer by nurses' station, 200 Hall Restroom, DON Office, 202 Bathroom, 200 Hall by exit door, and 300 Hall by exit door.</p> <p>Interview, on 05/22/13 between 2:30 PM and 4:00 PM, with the Housing Manager revealed he had just become aware of the sprinkler head requirement.</p>	K 056	<p>corrected to ensure facility sprinkler heads were not blocked by any fixtures. Fire sprinkler head extensions will be added on 7/5/13 for compliance with NFPA standards.</p> <p>2. All residents have the potential to be affected by the deficient practice. The Housing Manager will assure that all fire sprinklers are in compliance by a facility walk through on 7/8/13, after the sprinkler heads are corrected.</p> <p>3. A Preventative Maintenance Form to inspect the fire sprinkler system is to be completed every quarter and submitted to Housing Manager. A maintenance inservice was completed on 6/14/13 by the Housing Manager reviewing NFPA standards related to facility sprinkler heads not being blocked by light fixtures.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1800 WESTEN AVENUE BOWLING GREEN, KY 42104</b>		
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K 056	Continued From page 7  Reference: NFPA 13 (1999 Edition) 5-13 8.1  Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.  Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently	K 056	4. These Preventative Maintenance Forms will be submitted to the Administrator and forwarded to the QA committee on a quarterly basis for the next one (1) year for review and recommendations for changes. These forms will be submitted to QA annually thereafter.		

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K 056	Continued From page 8 away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)	K 056																										
	<p style="text-align: center;">Maximum Allowable Distance</p> <table border="0"> <tr> <td>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td>of Deflector Obstruction (in.)</td> </tr> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>21/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>31/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>51/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>71/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>91/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>161/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	21/2	1 ft 6 in. to less than 2 ft	31/2	2 ft to less than 2 ft 6 in.	51/2	2 ft 6 in. to less than 3 ft	71/2	3 ft to less than 3 ft 6 in.	91/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	161/2	5 ft and greater	18			
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4 ft 6 in. to less than 5 ft	161/2																											
5 ft and greater	18																											
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Transferring of oxygen is:  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;	K 143	K143 1. The mechanical vent was corrected on 5/24/13. The belt of the vent was not properly working and this was immediately repaired.	6/19/13																								

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K 143	<p>Continued From page 9</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to insure the room being used to transfer liquid oxygen had ventilation per NFPA requirements. The deficiency had the potential to affect one (1) of one (1) smoke compartments, residents, staff and visitors. The facility is certified for twenty eight (28) beds with a census of twenty five (25) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/22/13 at 3:36 PM, with the Housing Manager revealed the room which oxygen was being transferred had a mechanical vent that was not functional on the day of the survey.</p> <p>Interview, on 05/22/13 at 3:36 PM, with the Housing Manager revealed he was not aware mechanical vent had stopped working.</p>	K 143	<p>2. All other residents have the potential to be affected by this deficient practice. The oxygen room was inspected on 6/18/13 by maintenance staff and no issues were found.</p> <p>3. The Oxygen Room Audit form added monthly. A maintenance inservice was completed by the Housing Manager on 6/14/13 covering guidelines for the oxygen room.</p> <p>4. The Oxygen Room Audit will be submitted to the Housing Manager upon completion for review. After review, a copy will be provided to the Administrator for compliance. The Administrator will present to QA monthly for the next six months for review and recommendations for changes.</p>	

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K 143	Continued From page 10  4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be p for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthelizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, sw and re shall be installed in fixed locations not f 152 cm4 the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide	K 143			

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K 143	Continued From page 11 shall be kept free of flammable materials [ also 4-3.1.1.2(a) 7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [ Copyright NFPA 99 8-2.1.2.3(c)]. 10. Location of Supply Systems. a. Except as permitted by 4-3.1.1.2(a) 10c, supply systems for medical gases or mixtures of these gases having total capacities (connected and in storage) not exceeding the quantities specified in 4-3.1.1.2(b) 1 and 2 shall be located outdoors in an enclosure used only for this purpose or in a room or enclosure used only for this purpose situated within a building used for other purposes. b. Storage facilities that are outside, but adjacent to a building wall, shall be in accordance with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites. c. Locations for supply systems shall not be used for storage purposes other than for containers of	K 143			

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K 143	<p>Continued From page 12</p> <p>nonflammable gases. Storage of full or empty containers shall be permitted. Other nonflammable medical gas supply systems or storage locations shall be permitted to be in the same location with oxygen or nitrous oxide or both. However, care shall be taken to provide adequate ventilation to dissipate such other gases in order to prevent the development of oxygen-deficient atmospheres in the event of functioning of cylinder or manifold pressure-relief devices.</p> <p>d. Air compressors and vacuum pumps shall be located separately from cylinder patient gas systems or cylinder storage enclosures. Air compressors shall be installed in a designated mechanical equipment area, adequately ventilated and with required services.</p> <p>a. Walls, floors, ceilings, roofs, doors, interior finish, shelves, racks, and supports of and in the locations cited in 4-3.1.1.2(a) 10a shall be constructed of noncombustible or limited-combustible materials.</p> <p>b. Locations for supply systems for oxygen, nitrous oxide, or mixtures of these gases shall not communicate with anesthetizing locations or storage locations for flammable anesthetizing agents.</p> <p>c. Enclosures for supply systems shall be provided with doors or gates that can be locked.</p> <p>d. Ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5ft(1.5 m) above the floor to avoid physical damage.</p> <p>e. Where enclosures (interior or exterior) for supply systems are located near sources of heat, such as furnaces, incinerators, or boiler rooms, they shall be of construction that protects</p>	K 143		

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K 143	Continued From page 13 cylinders from reaching temperatures exceeding 130°F (54°C). Open electrical conductors and transformers shall not be located in close proximity to enclosures. Such enclosures shall not be located adjacent to storage tanks for flammable or combustible liquids. f. Smoking shall be prohibited in supply system enclosures. Copyright NFPA g. Heating shall be by steam, hot water, or other indirect means. Cylinder temperatures shall not exceed 130°F (54°C). (b) Additional Storage Requirements for Nonflammable Gases Greater Than 3000 ft (85 m). 1. Oxygen supply systems or storage locations having a total capacity of more than 20,000 ft (566 m (NTP), including unconnected reserves on hand at the site, shall comply with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites. 2. Nitrous oxide supply systems or storage locations having a total capacity of 3200 lb (1452 kg) [ 793 m (NTP)] or more, including unconnected reserves on hand at the site, shall comply with CGA Pamphlet G-8.1, Standard for the Installation of Nitrous Oxide Systems at Consumer Sites. 3. The walls, floors, and ceilings of locations for supply systems of more than 3000 ft (85 m total capacity (connected and in storage) separating the supply system location from other occupancies in a building shall have a fire resistance rating of at least 1 hour. This shall also apply to a common wall or walls of a supply system location attached to a building having other occupancy. 4. Locations for supply systems of more than	K 143		