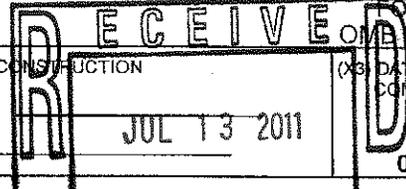


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2011



FORM APPROVED
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 06/07/2011
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702
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F 000	INITIAL COMMENTS A standard health survey was initiated on May 31, 2011, and concluded on June 7, 2011. Immediate Jeopardy was identified on June 2, 2011, and determined to exist on May 31, 2011. An extended survey was conducted on June 7, 2011. Deficiencies were cited at 483.65 Infection Control (F441), and 483.75 Administration (F490) and (F520) at a scope and severity of "J." **An acceptable allegation of compliance was received on June 3, 2011, which alleged removal of Immediate Jeopardy on June 4, 2011. An extended survey was conducted on June 7, 2011, which determined the Immediate Jeopardy was removed on June 4, 2011. The scope/severity for F441, F490, and F520 was lowered to 'D.'	F 000	Preparation or 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 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide a sanitary, orderly, and comfortable interior. Drywall was chipped and marred, call bell cords were inappropriately lengthened, a commode tank was cracked and did not fit the tank, a dresser handle, towel bar, and glove container box were loose, and a privacy curtain was stained.	F 253	F 253 Environmental 1. The maintenance and housekeeping staff has corrected the following identified issues. (a)Commode tank cover in room 219 has been replaced. (b) The emergency call cords in bathrooms 206 and 216 have been replaced. (c) The dresser handle in 309 has been repaired. (d) The towel bar in room 303 has been repaired. (e) The glove box container in room 223 has been repaired. (f) The privacy curtain in room 214 has been replaced. (g)The drywall above bed 2 in room 209 has been repaired. (h) The drywall above the baseboard at the entry door of room 211 has been repaired. (i) The drywall above bed 309-2 has been repaired. (j) The drywall above the baseboard at the third floor (elevator hall) shower room has been repaired. 2. All commode lids in the resident care areas have been checked and replaced by maintenance, as needed. All the emergency call cords in the resident bathrooms and central locations have been checked and replaced by maintenance, as needed. All the resident	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bill Collins</i>	TITLE Administrator	(X6) DATE 07/12/2011
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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 253	<p>Continued From page 1</p> <p>The findings include:</p> <p>During the environmental tour of the facility on May 31-June 2, 2011, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> -A commode tank cover was observed to have a large crack and the tank cover was too large/did not fit the tank in resident bathroom 219. -The emergency call bell cord in resident bathrooms 206 and 216 was short; however, the facility failed to ensure an appropriate cord had been attached to lengthen the emergency call bell cord. A gold-colored cord had been tied to the emergency call bell cord to lengthen the call bell cord in resident bathroom 206 and a pastel ribbon had been tied to the emergency call bell cord to lengthen the call bell cord in resident bathroom 216. -The dresser handle to the bottom drawer in resident room 309 was not secured to the dresser. -The towel bar in resident room 303 was loose. -The container that held the box of gloves was dangling from the wall in resident bathroom 223. -The privacy curtain in resident room 214 was observed to be stained with numerous thick black marks. -The drywall above bed 2 in resident room 209 was observed to have large, deep, vertical scrapes. -The drywall was scraped above the baseboard at the entry door of resident room 211. -The drywall was marred and scraped above bed 2 in resident room 309. -The drywall had bubbled and flaked, and was scraped above the baseboard near the entrance 	F 253	<p>dresser handles have been checked and repaired by maintenance, as needed. All the resident towel bars in their rooms and common areas have been checked and either repaired or changed by maintenance, as needed. All the glove box containers have been checked by maintenance and repaired, as needed. All the resident privacy curtains have been inspected by housekeeping and either washed or replaced, as needed. All the drywall above the resident beds and in the hallways have been inspected by maintenance and repaired as indicated.</p> <p>3. The Nursing, Housekeeping, QA Team and Maintenance Departments were re-educated by the Administrator and/or his designee between June 29 - July 1, 2011 (unless on medical/personal leave or vacation). The education consisted of environmental issues for safety of residents (spills, call/pull cords, etc), maintenance concerns (frayed wires, electrical problems, elevator problems, etc.), and housekeeping concerns (privacy curtains, loose handles/devices). Education further consisted of the "work requests" - how to utilize, when to utilize, who was to use request forms and where to place requests when completed by employees so maintenance/housekeeping could locate work requests. The QA Committee's education (6/3, 6/10, 6/13/11) consisted of review of the Monday-Friday QA round sheet (areas to look for when doing rounds)and how to complete CRAF forms on any concerns/problems identified.</p>		

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F 253	Continued From page 2 door of the 3rd floor (elevator hall) shower room. An interview conducted with the Assistant Maintenance Supervisor (MS) on June 2, 2011, at 1:30 p.m., revealed the facility utilized a work order system. The Assistant MS stated any staff member could obtain a Repair Requisition at the nurses' station to inform the Maintenance Department of anything that needed to be repaired. The Assistant MS stated staff also informed him verbally or by phone of items in need of repair. The Assistant MS revealed a thorough check of one room per day was conducted to look for any items in need of repair. A review of facility work orders revealed the above concerns had not been identified by the facility. In addition, the Assistant MS confirmed work orders had not been completed for the identified concerns and had not been identified during room checks.	F 253	Conclusions is what analysis you came up with of audit findings. Recommendations are from QA Committee on how to fix problems/concerns. Actions is what you get done from the recommendations of QA. Follow up is how soon are you going to audit again. 4. QA Committee members present Monday through Friday will continue QA walking rounds in the resident care areas as assigned by the Administrator. The areas will include resident rooms, central bath/showering, linen closets, Florida rooms and medication rooms. The areas checked will be related to safety, resident care, housekeeping and maintenance issues. Walking rounds will be made at diverse times throughout the day and reported at next Monday - Friday QA meeting. The housekeeping department, as assigned by the Housekeeping Supervisor, will audit a minimum of 25 resident areas per month to specifically inspect the drywall, emergency call cords, and privacy curtains for appropriate devices, cleanliness and needed repairs. The Housekeeping Supervisor will bring this report to QA on a monthly basis for three months then as designated by the QA Committee.		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide foods that were at a palatable temperature during the lunch meal on June 1, 2011.	F 364	1. On June 1, 2011 at the noon meal on second floor a new tray and a new mighty shake was obtained for the resident # 1, when the tray had not been served within	7/01/11	

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F 364	<p>Continued From page 3</p> <p>The findings include:</p> <p>A review of the Meal Temperature policy (not dated) revealed the Dietary Department would serve food that was at appropriate temperatures. The policy noted the minimum temperatures for chilled foods, milk, and juices should be 40 to 45 degrees Fahrenheit. Further review of the policy revealed meal trays would be served to residents within 25 minutes of the cart being delivered to the units. The policy further directed staff that if trays remained on a cart longer than 25 minutes the temperatures of the foods may not be appropriate and a new tray should be requested.</p> <p>Observation of the noon meal service on June 1, 2011, revealed the first resident meal tray was delivered to the second floor dining room from the kitchen in a closed, unheated cart at 12:10 p.m. A second closed, unheated cart was delivered to the second floor dining room at 12:20 p.m. The last tray was removed from the second food cart at 12:47 p.m. (27 minutes after the cart was delivered). The tray was removed from the cart by Certified Nurse Aide (CNA) #4 but was intercepted by the surveyor and a new resident tray was requested. A temperature and palatability test conducted with the Consultant Dietitian revealed the pureed foods were warm and palatable; however, the temperature of a "mighty shake" (dairy-based high protein/high calorie nutritional supplement) was 52.3 degrees Fahrenheit.</p> <p>An interview with the Consultant Dietitian (CD) on June 1, 2011, at 12:50 a.m., revealed monthly test trays had been conducted and no problem with food temperatures had been identified. The</p>	F 364	<p>25 minutes of the food cart being brought to the floor. (Deficiency did not contain a resident #, however it was Resident # 1 on the exit Resident Roster)</p> <ol style="list-style-type: none"> All orders for supplements with meals were reviewed by the Dietitian effective July 2, 2011. Supplements will be rescheduled to be delivered as between meal snacks. The shakes will be chilled in freezer to lower the temperature prior to each service period and transported to resident care units on a pan of ice. The Dietitian and the Dietary Manger promptly began tray audits to test hot and cold food temperatures. No further problems were noted at that time. The Consulting Dietitian (CD), the Dietary Manager (DM), Director of Nursing (DON), and Administrator reviewed and revised the meal temperature policy between June 29 - July 1, 2011. The CD or designee re-educated the dietary department and the nursing department. The education related to the meal temperature policy, how the mighty shakes will be labeled and delivered to each unit and the process to ensure supplements and foods are served at an appropriate temperature and passed in a timely manner. Nursing will sign snack/supplement list when transported to the units and the Charge Nurse will ensure snacks are passed within 25 minutes of delivery. Also, timers were purchased for each trolley to remind staff when they should request a new tray. Timers will be set by dietary staff at 25 		

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F 364	Continued From page 4 CD stated milk and milk products should be served at a temperature below 40 degrees Fahrenheit. The CD stated the above recommended temperature of the "mighty shake" would not have harmed the resident but if served at a higher than recommended temperature the "mighty shake" would not have been palatable. In addition, the CD stated a "mighty shake" that had not been refrigerated for two to four hours and consumed by a resident could cause the resident to develop a foodborne illness. The CD stated frozen "mighty shakes" were delivered to the facility; staff thawed the "mighty shakes" in the refrigerator prior to placing the "mighty shake" on a resident tray. The CD stated the elevated temperature of the "mighty shake" had to be caused by being on the tray and cart with the other hot foods. An interview was conducted with CNA #4 on June 1, 2011, at 1:00 p.m. CNA #4 stated meal trays should be delivered to residents within 15 minutes of the cart being delivered to the unit. CNA #4 stated the CNA should have requested a replacement tray for the resident since the tray had remained on the cart too long.	F 364	minutes when trolleys arrive on each resident unit. 4. Two Quality Audits will be conducted by the Dietary Manager (DM) and/or the Consulting Dietitian (CD). Six (6) tests trays will be monitored weekly for one month, then bi-weekly times one month, then quarterly for three (3) months, then as directed by the QA Committee. Ten (10) alert and oriented residents will be interviewed by the DM and/or CD regarding satisfaction with food temps. These audits will be conducted weekly for one (1) month, bi-weekly for one (1) month and then quarterly for three (3) months, then as directed by the QA Committee. The DM will bring findings to the monthly QA meeting for review and continued action as needed.	7/01/11
F 441 SS=J	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	F 441 1. CMT # 1 was re-educated June 3, 2011 by the MDS Coordinator related to disinfecting the Blood Glucose Monitors (BGM) and competency was verified by return demonstration June 3 - June 9, 2011. Licensed Nurse's assessed Resident's # 3, 16 and 17's fingertips and temperature to ensure neither of the three residents had any signs and symptoms of infection. The three residents in this care	

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F 441	<p>Continued From page 5</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy and procedure review, and review of manufacturer's recommendations, it was determined the facility failed to have an effective Infection Control Program in place to provide a safe environment to prevent the development and transmission of disease and infection. The facility failed to</p>	F 441	<p>group had no identified blood infections on June 29, 2011. C.N.A. # 3 was re-educated by the Director of Nurses (DON) related to passing ice and the importance of the ice scoop not coming in contact with the ice in the chest or the ice machine. On June 30, 2011 the residents in rooms 215, 216 were assessed by a Licensed Nurse and had no signs and symptoms of infection. The ice cooler and scoop were sanitized. On June 29, 2011 the wound care nurse was re-educated by the DON related to infection control techniques, specifically washing of hands after removal of gloves. On June 30, 2011 resident # 5's wound was assessed by a Licensed Nurse and had no signs and symptoms of infection.</p> <p>2. On June 3, 2011 all in-house residents who required BGM were assessed by Licensed Nurses. Between June 3 - June 9, 2011 the resident's fingertips and temperatures were assessed to ensure there was no development of infection. No problems were identified. Between June 30 - July 1, 2011 the residents on second floor, were assessed by licensed nurses related to any signs and symptoms of infection due to the ice scoop remaining in the ice cooler while passing ice. No problems were identified. Between June 30 - July 1, 2011 all the in house facility residents who had pressure ulcers were assessed by a licensed nurse and have no signs and symptoms of infection related to the wound care nurse not washing hands after removing the gloves</p>		

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F 441	<p>Continued From page 6</p> <p>ensure resident multi-use Blood Glucose Monitors (BGMs) were disinfected between each resident use according to the facility's policy and manufacturer's recommendations. CMT #1 was observed performing blood glucose monitoring via fingerstick without disinfecting the BGM before and after use for three of twenty-four sampled residents (residents #3, #16, and #17). It was further determined the facility failed to provide evidence the facility's infection control program was effective in ensuring the competency of CMT #1 in the proper technique to disinfect resident glucometer devices as recommended by the facility's policy, CDC guidelines, and the glucometer manufacturer's recommendation. In addition the facility staff failed to pass ice to residents under sanitary conditions on May 31, 2011, at 3:50 p.m., and the facility wound/treatment nurse was observed to not wash hands when indicated during wound care for resident #5 on June 1, 2011. (Refer to F490 and F520.)</p> <p>The facility's failure to have an effective infection control program placed residents at risk for serious injury, harm, impairment, and death.</p> <p>The findings include:</p> <p>1. According to the Centers for Disease Control (CDC) Guidelines, updated March 23, 2011, "Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not</p>	F 441	<p>on resident # 5's treatment.</p> <p>3. On June 2, 2011 the Manufacturer's Guidelines for disinfection of the Glucometers were reviewed by the Director of Nursing (DON), Clinical Nurse Consultant (CNC) and the Administrator. The facility currently utilizes the Assure 4 meter. The guidelines do reflect the Assure 4 meter is adequately disinfected with the Super Sani-Cloth Germicidal disposable wipes that the facility utilizes. On June 3, 2011 the DON re- educated the Central Supply Clerk that she is to order the Super Sani-Cloth Germicidal wipes. On June 2, 2011 the Glucometer Disinfecting Guidelines were reviewed and revised by the DON. On June 2, 2011 a Check Off/Competency form was developed by the DON and the CNC. The Check Off/Competency and the Glucometer Disinfecting Guidelines follow the manufacturer guidelines for cleaning and disinfecting the Assure 4 meter. On June 2, 2011 the CNC re-educated the Staff Development Coordinator (SDC) and the MDS Coordinator related to the revised guidelines for appropriate disinfecting of the glucometers. Competency was established by return demonstration. On June 3, 2011 a staff RN was educated and competency was verified by the MDS Coordinator. The SDC, MDS Coordinator and the Staff RN re-educated all the RN's, LPN's and CMT's with return demonstration of disinfecting the glucometers. Between June 29 - July 1, 2011 the DON re-educated all nursing staff related to</p>	

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F 441	<p>Continued From page 7 specify how the device should be cleaned and disinfected then it should not be shared."</p> <p>The facility's policy "Glucometer Cleaning Guidelines" (dated February 2011) revealed the glucometer was required to be cleaned between each patient/resident test according to the facility's policy. The RN, LPN, and/or CMT should use super sani-cloth germicidal wipes to disinfect the glucometer. The meter should be visibly cleaned/wet for two minutes and allowed to dry for 15 seconds. If the meter was visibly soiled, it should be cleaned with one wipe and a second wipe should be used to disinfect the meter.</p> <p>According to the manufacturer's recommended guidelines for disinfection of the Assure 4 glucometer used by the facility, a dilute of 1 milliliter of household bleach (5%-6% sodium hypochlorite solution) in 9 milliliters of water to achieve a 1:10 dilution (final concentration of 0.5% - 0.6% sodium hypochlorite) should be used. The solution should be used to dampen a paper towel (do not saturate the towel); then use the dampened paper towel to thoroughly wipe down the meter. There were commercially available 1:10 bleach wipes from a variety of manufacturers. Super Sani-Cloth Germicidal Disposable Wipe was included as an effective disinfectant for use on the Assure 4 glucometer.</p> <p>A record review revealed resident #3 was admitted to the facility on January 24, 2007, with diagnoses of Diabetes Mellitus with Gastroparesis, Urinary Retention, Diabetic Neuropathy, Embolism of the lower extremity, and a History of Alcohol and Tobacco Abuse.</p>	F 441	<p>appropriate passing of ice to prevent spreading of micro-organisms. Between June 29 - July 1, 2011 the DON re-educated all the nursing staff related to infection control practice, specific to washing hands after removal of gloves.</p> <p>4. The SDC, MDS Coordinator and the Staff RN will re-educate with return demonstration to ensure competency of all the RN's, LPN's and CMT staff bi-weekly for two months, monthly for two months, then as directed by the QA Committee related to disinfecting the glucometer meters. The DON will review the competencies for additional action if indicated related to the glucometers. The DON, or designee, will conduct an ice pass audit monthly for three months to ensure the ice is passed according to current guidelines related to infection control practices. The DON will forward data to QA Committee monthly for three months. Then as designated by the QA Committee. The DON, or designee, will conduct a monthly audit for three months related to hand washing after glove removal to ensure appropriate infection control guidelines are being practiced. The DON will forward data to QA Committee monthly for three months. Then as directed by the QA Committee.</p>	7/01/11
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F 441	<p>Continued From page 8</p> <p>Resident #3 had physician's orders for blood glucose monitoring two times a day and received hypoglycemics as therapeutic treatment.</p> <p>A review of resident #16's medical record revealed the resident was admitted to the facility on November 16, 2010, with diagnoses of Esophageal Dysmotility, Dysphagia, and Diabetes Mellitus II. Resident #16 had physician's orders for blood glucose monitoring two times a day.</p> <p>During observation of a medication pass conducted on May 31, 2011, at 3:10 p.m., Certified Medication Technician (CMT) #1 was observed to obtain resident #3's blood glucose via fingerstick. CMT #1 was observed to clean the blood glucose monitor with an alcohol pad, and then obtain resident #16's blood glucose via fingerstick. The CMT then used an alcohol pad to clean the blood glucose monitor after obtaining the blood sample and placed the glucometer back into a medication cart drawer. CMT #1 failed to ensure the glucometer was disinfected per manufacturer's guidelines and facility policy.</p> <p>An interview conducted with CMT #1 on May 31, 2011, at 3:10 p.m., revealed CMT #1 had been trained to sanitize the BGM with alcohol after use to check blood sugar and to also use alcohol as a cleaning/sanitizing agent between residents.</p> <p>A record review revealed resident #17 was admitted to the facility on December 23, 2010, with medical diagnoses of Diabetes Mellitus II, Hypertension, Skin Cancer, Hypercholesterolemia, Asthma, Confusion, Arthritis, Anxiety, and History of Colon Cancer. Resident #17 had a physician's order dated May</p>	F 441			

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F 441	<p>Continued From page 9</p> <p>2011 for glucose monitoring via fingerstick four times a day and as needed.</p> <p>During observation of a medication pass conducted on May 31, 2011, at 3:30 p.m., Certified Medication Technician (CMT) #1 performed a blood glucose check for resident #17 and failed to disinfect the glucometer prior to use or after use. Observations revealed CMT #1 cleaned the BGM with an alcohol pad prior to obtaining resident #17's blood glucose via fingerstick, used an alcohol pad to clean the BGM after obtaining the blood sample, and placed the meter back in a drawer on the medication cart.</p> <p>An interview conducted on May 31, 2011, at 3:35 p.m., with CMT #1 revealed she had been trained to disinfect the glucometer used for resident #17 with an alcohol prep pad.</p> <p>An additional interview conducted on June 1, 2011, at 3:25 p.m., with CMT #1 revealed she had been in-serviced a couple of months ago (unable to recall exact date) on the facility's policy and procedure to clean and disinfect the resident's BGM by the Infection Control Nurse (ICN) and Licensed Practical Nurse (LPN) #1, the Third Floor Supervisor. CMT #1 was unable to recall specifics of the in-service but believed she was supposed to use an alcohol prep pad to disinfect the resident glucometers before and after performing a blood glucose test.</p> <p>An interview conducted on June 1, 2011, with LPN #1, the Third Floor Supervisor, revealed she was responsible to do immediate one-on-one retraining with the individual staff member in the event of failure to follow policy and procedure.</p>	F 441			

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F 441	<p>Continued From page 10</p> <p>LPN #1 revealed the facility's policy for BGM disinfecting had changed several months ago (unable to recall date) and all Registered Nurses (RNs), LPNs, and CMTs had been in-serviced on the facility's updated policy and procedure. The staff confirmed BGMs were required to be disinfected with a Super Sani-Cloth Germicidal Disposable Cloth before and after a resident blood glucose test was performed.</p> <p>An interview conducted on June 2, 2011, at 3:15 p.m., with the Infection Control Nurse (ICN), revealed she was responsible for providing in-service education for CMTs, LPNs, and RNs on the facility's updated policies and procedures and to perform audits/reviews of staff to evaluate and assure competency of the training provided. The ICN stated an in-service training on "Glucometer Cleaning Guidelines" for CMTs, LPNs, and RNs was conducted on February 15, 2011, and again on March 1, 2011. The ICN did not recall an audit of CMT #1's competency regarding the facility's policy/procedure on BGM Cleaning Guidelines and was unable to provide evidence of an evaluation of CMT #1's competency.</p> <p>An interview conducted on June 2, 2011, at 6:10 p.m., with the Director of Nursing (DON) revealed the facility had updated the BGM disinfectant policy in February 2011, and the ICN was responsible for providing training and monitoring CMTs, LPNs, and RNs on this new policy update. The DON further stated the facility had not identified any staff problems with failure to follow the facility's policy and procedure of disinfecting a resident's BGM. The DON confirmed the facility's policy was to disinfect the BGM before and after</p>	F 441			

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F 441	<p>Continued From page 11</p> <p>resident testing with a Super Sani-Cloth Germicidal Disposable Wipe. The DON stated according to the facility's policy and procedure and CDC guidelines, the use of an alcohol prep pad to disinfect the resident's glucometers had a potential for the transmission of bloodborne pathogens/infections to the staff using the glucometer and residents.</p> <p>2. The facility policy titled Ice Machines and Ice Storage Chests (revised December 2009) directed staff that to prevent contamination of ice machines, ice storage chests/containers of ice, staff should keep the ice scoop/bin in a covered container when not in use.</p> <p>Observation on May 31, 2011, at 3:50 p.m., revealed CNA #3 passed ice to resident rooms on the second floor. Observation revealed CNA #3 filled an ice pitcher for an unsampled resident in room 215; however, CNA #3 left the ice scoop in the ice chest with the handle touching the ice that remained in the ice cooler.</p> <p>Further observation revealed CNA #3 entered resident room 216 and obtained an ice pitcher for an unsampled resident. CNA #3 was observed to handle/touch the resident's bedside table and bathroom door knob, empty the water from the ice pitcher in the resident's bathroom, open the ice cooler, grasp the ice scoop that was lying on the ice in the cooler, and fill the resident's pitcher with ice. CNA #3 then left the ice scoop in the ice chest with the handle touching the ice that remained in the ice cooler.</p> <p>Further observation on May 31, 2011, at 4:10 p.m., revealed CNA #3 stored the ice cooler in</p>	F 441			

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F 441	<p>Continued From page 12</p> <p>the second floor utility room and the ice scoop remained inside the cooler with the handle in contact with the ice.</p> <p>Interview on June 1, 2011, at 4:00 p.m., with CNA #3 revealed the CNA was knowledgeable of the requirement to store the ice scoop in the covered container that was positioned on the shelf below the ice cooler. CNA #3 stated he just failed to use the storage container and left the ice scoop in the ice chest by mistake. CNA #3 stated the handle of the ice scoop should not come in contact with the ice that was to be served to residents.</p> <p>3. A review of the facility policy for hand washing and the use of gloves dated December 1998 revealed staff was required to wash their hands after removing gloves with a specific note which indicated gloves do not replace hand washing.</p> <p>Observation of wound care for resident #5 on June 1, 2011, at 3:35 p.m., revealed the facility's wound treatment nurse removed a soiled dressing from the coccyx area of resident #5, removed the soiled gloves from her hands, donned clean gloves, and cleaned the wound area. The wound treatment nurse removed her soiled gloves after cleaning the wound area, donned clean gloves, and applied a dressing to the wound on the coccyx area of resident #5. The wound care nurse failed to wash her hands after removing her soiled gloves and donning clean gloves.</p> <p>An interview conducted with the wound treatment nurse on June 1, 2011, at 3:35 p.m., revealed the wound treatment nurse washed her hands prior to</p>	F 441			

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F 441	<p>Continued From page 13</p> <p>starting the treatment and after the treatment was complete. Further interview revealed the wound treatment nurse was not aware that handwashing was required after removing gloves.</p> <p>**An acceptable Allegation of Compliance was received on June 3, 2011, which alleged removal of Immediate Jeopardy on June 4, 2011. An extended survey was conducted on June 7, 2011, which determined the Immediate Jeopardy was removed on June 4, 2011. A review of the Allegation of Compliance and verification revealed the following:</p> <p>The residents that received glucose checks by CMT #1 had a visual inspection of their fingers and temperatures taken on June 3, 2011, by a Licensed Nurse; no signs of infection or elevated temperatures were noted.</p> <p>All residents receiving blood glucose monitoring had visual inspection of their fingers and temperatures taken on June 3, 2011, by a Licensed Nurse. No signs of infection were noted nor any elevated temperatures.</p> <p>The Manufacturer Guidelines for the Assure 4 glucometer on disinfection of the glucometers were reviewed by the Director of Nursing, Clinical Nurse Consultant (CNC), and the Administrator on June 3, 2011. The guidelines reflected the Assure 4 meter was adequately disinfected with the Super Sani-Cloth Germicidal Disposable Wipes that the facility utilized. The Central Supply clerk was educated by the DON to only order Super Sani-Cloth Germicidal. The Glucometer Disinfecting Guidelines were reviewed and revised by the DON on June 2,</p>	F 441			

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F 441	<p>Continued From page 14</p> <p>2011. A check-off/competency form following the manufacturer's guidelines for cleaning and disinfecting the Assure 4 meter was developed by the DON and CNC on June 2, 2011.</p> <p>The CNC reeducated the Staff Development Coordinator (SDC) and the MDS Coordinator related to the revised guidelines for appropriate disinfecting of the glucometers. Competency was established by return demonstration on June 2, 2011.</p> <p>A staff RN was educated and competency tested by the MDS Coordinator on June 3, 2011. She assisted with the staff training on June 3, 2011.</p> <p>Reeducation for all RN, LPN, and CMT staff with return demonstration of disinfection on the glucometers by the Staff Development Coordinator, the MDS Coordinator, and a staff RN began on June 3, 2011, and was completed on June 3, 2011.</p> <p>The SDC, MDS Coordinator, and the staff RN will reeducate with return demonstration to ensure competency of all the RN, LPN, and CMT staff bi-weekly for two months, monthly for two months, and then as recommended by the Quality Assurance Committee.</p> <p>Review of residents #3, #16, and #17's records revealed staff had documented on June 6, 2011, that the residents had no signs or symptoms of infection, elevated temperature, or identified blood infections. The monitoring sheet was added to the residents' Medication Administration Record (MAR).</p>	F 441		

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F 441	<p>Continued From page 15</p> <p>The facility updated the Glucometer Disinfecting Guideline (dated June 2, 2011) to reflect CDC guidelines to prevent the spread of actual and/or potential infections between patients/residents. A review of Glucometer Check-off Competency Forms dated June 3, 2011, revealed all nurses and CMTs demonstrated competency with Manufacturer's Guidelines for disinfecting the glucometer.</p> <p>Observations and interviews conducted June 7, 2011, from 12:30 to 4:00 p.m., with CMTs, LPNs, and RNs who performed blood glucose monitoring for residents revealed staff had been trained by the facility and competency established by return demonstration on the facility's blood glucose monitoring policy. Observations conducted on June 7, 2011, from 12:30 to 4:00 p.m., revealed LPN and RN staff demonstrated proper technique for blood glucose monitoring according to the facility's policy and procedure and CDC guidelines when performing resident blood glucose monitoring.</p> <p>An interview conducted with CMT #1 (via telephone) on June 7, 2011, at 2:40 p.m., revealed she had been trained on blood glucose monitoring with return demonstration of competency on June 3, 2011.</p> <p>Interview with the DON conducted on June 7, 2011, at 5:15 p.m., revealed the facility had reviewed and updated the blood glucose monitoring policy and procedure to follow the manufacturer's recommended disinfectant guidelines and CDC Guidelines. The facility had developed a competency check-off sheet to assure staff competency of training. The DON</p>	F 441		

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F 441	Continued From page 16 confirmed all CMTs, LPNs, and RNs who worked at the facility had been in-serviced by the facility on the updated policy and procedure for blood glucose monitoring. Return demonstrations were performed to assure competency. Based on the above findings, it was determined the Immediate Jeopardy was removed on June 4, 2011. Noncompliance continued with scope and severity lowered to "D" based on the facility's need to evaluate the effectiveness of CQI activities related to the implementation of Policies and Procedures for the Infection Control Program.	F 441			
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 observation, interview, record review, and facility policy review it was determined the facility failed to ensure it was administered in a manner that enabled the facility to use resources effectively and efficiently to attain or maintain the highest practicable physical well-being of residents. Certified Medication Technician (CMT) #1 failed to disinfect a blood glucose monitor (BGM) between resident use for three of twenty-four sampled residents. The facility's failure to not have an effective	F 490	F 490 1. On June 3, 2011 CMT # 1 was re-educated by the MDS Coordinator related to disinfecting the Blood Glucose Monitors (BGM) and competency was verified by return demonstration. Between June 3 - June 9, 2011 residents' # 3, 16 and 17 fingertips were assessed and temperature was monitored to ensure neither of the three residents had any signs and symptoms of infection. The three residents in this care group had no identified blood infections. 2. Between June 3 - June 9, 2011 all in-house residents who required BGM had visual inspections of their fingertips and their temperatures were assessed to ensure there was no development of infection. No problems were identified. Information was forwarded to QA Committee and Administrator.		

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F 490	<p>Continued From page 17</p> <p>infection control program to ensure staff followed facility policy and current CDC guidelines related to BGM disinfecting guidelines for multiple resident use and to prevent the potential development and transmission of infections placed residents at risk for serious injury, harm, impairment, or death. (Refer to F441 and F520.)</p> <p>The findings include:</p> <p>A review of the facility policy Titled Glucometer Cleaning Guidelines (dated February 2011) revealed the BGM should be cleaned between each resident test with a Super Sani-Cloth Germicidal Disposable Wipe.</p> <p>On May 31, 2011, CMT #1 was observed to perform fingerstick blood tests on residents #3, #16, and #17 without disinfecting the BGM using the required disinfectant according to the facility policy between each resident use.</p> <p>An interview conducted with the facility's Administrator on June 2, 2011, at 6:45 p.m., revealed the Administrator was made aware of the Centers for Disease Control (CDC) Guidelines and Regulatory Changes regarding the Use of Blood Glucose Monitoring Machines by the facility's Corporate Representative in February 2011. According to the Administrator, the facility policy was revised to include the recommendations to clean and disinfect the BGMs between residents. In addition, in-services were conducted and staff trained on the new policy. The Administrator was not aware of any monitoring regarding staff competency or regarding the cleaning and sanitizing of the BGM. In addition, the Administrator stated blood</p>	F 490	<p>3. On June 2, 2011 the Manufacturer's Guidelines for disinfection of the Glucometers were reviewed by the Director of Nursing (DON), Clinical Nurse Consultant (CNC) and the Administrator. The facility currently utilizes the Assure 4 meter. The guidelines do reflect the Assure 4 meter is adequately disinfected with the Super Sani-Cloth Germicidal disposable wipes that the facility utilizes. On June 3, 2011 the DON re- educated the Central Supply Clerk that she is to order the Super Sani-Cloth Germicidal wipes. On June 2, 2011 the Glucometer Disinfecting Guidelines were reviewed and revised by the DON. On June 2 and June 3, 2011 the guidelines were approved by the Administrator and Medical Director. on June 2, 2011 a Check Off/Competency form was developed by the DON and the CNC. The Check Off/Competency and the Glucometer Disinfecting Guidelines follow the manufacturer guidelines for cleaning and disinfecting the Assure 4 meter. On June 2, 2011 the CNC re-educated the Staff Development Coordinator (SDC) and the MDS Coordinator related to the revised guidelines for appropriate disinfecting of the glucometers. Competency was established by return demonstration. On June 3, 2011 a staff RN was educated and competency was verified by the MDS Coordinator. The SDC, MDS Coordinator and the Staff RN re-educated all the RN's, LPN's and CMT's with return demonstration of disinfecting the glucometers on June 3, 2011.</p>		

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F 490	<p>Continued From page 18</p> <p>glucose monitoring machines had been purchased for each resident that required the machine, but were not being utilized due to lack of storage space for the machines. Further interview revealed the facility had looked into purchasing carts for the machines, but had not decided on a particular cart. Additional interview with the Administrator revealed that infection control was reviewed monthly during the Quality Assurance Meeting related to the number of infections and for an increase of infections, but infection control was not reviewed regarding staff knowledge of practices and procedures related to infection control.</p> <p>**An acceptable Allegation of Compliance (AOC) was received on June 3, 2011, which alleged removal of Immediate Jeopardy on June 4, 2011. An extended survey was conducted on June 7, 2011, which determined the Immediate Jeopardy was removed on June 4, 2011. A review of the Allegation of Compliance and verification revealed the following:</p> <p>A review of the AOC revealed that residents who had received blood glucose monitoring checks by CMT #1 were assessed on June 3, 2011, and monitored daily each shift for signs and symptoms of infections with no concerns identified.</p> <p>The facility policy for the cleaning/disinfecting of BGMs was reviewed and revised on June 2, 2011, by the Director of Nursing (DON) and all staff that utilizes the BGMs was retrained and competency was verified by return demonstration with monitoring and reeducation bi-weekly for two months ongoing.</p>	F 490	<p>4. The SDC, MDS Coordinator and the Staff RN will re-educate with return demonstration to ensure competency of all the RN's, LPN's and CMT staff bi-weekly for two months, monthly for two months, then as directed by the QA Committee related to disinfecting the glucometer meters. The DON will review the competencies for additional action if indicated related to the glucometers and the CNC will review with the Administrator the QA Committee Agenda, action plans, monitoring audits, and the revision of action plans if so identified to ensure the facility is appropriately engaged in the QA process. This will occur monthly for three months at minimum.</p>	7/01/11	

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F 490	<p>Continued From page 19</p> <p>A review of in-service documents dated June 3, 2011, revealed the Administrator was in-serviced by the Clinical Nurse Consultant (CNC) regarding the QA process to identify quality deficiencies and staff competency on June 3, 2011.</p> <p>A review of QA meeting minutes revealed the Administrator had conducted QA meetings to identify concerns on June 3, 6, and 7, 2011, with no concerns identified according to the meeting minutes.</p> <p>Observations and interviews on June 7, 2011, from 12:30 to 4:00 p.m., of staff completing blood glucose monitoring checks on residents revealed the staff had been in-serviced related to blood glucose monitoring and observations of blood glucose monitoring checks conducted by the staff revealed no concerns.</p> <p>An interview conducted with the Administrator on June 7, 2011, at 6:30 p.m., revealed the blood glucose monitoring policy had been revised on June 2, 2011. All staff had been trained regarding disinfecting the BGM with competency determined by repeat demonstration on June 3, 2011, and daily monitoring was ongoing of diabetic residents for signs and symptoms of infection.</p> <p>Based on the above findings, it was determined the Immediate Jeopardy was removed on June 4, 2011. Noncompliance continued with scope and severity lowered to "D" based on the facility's need to evaluate the effectiveness of CQI activities related to the implementation of Policies and Procedures for the Infection Control Program</p>	F 490			

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OMB NO. 0938-0391

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F 490	Continued From page 20 and the Administrator's oversight and monitoring of the Infection Control Program.	F 490			
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to identify issues for which quality assessment and assurance activities were necessary, and failed to develop and implement appropriate	F 520	F 520 1. On June 3, 2011 the CNC re-educated the Administrator, Director of Nursing (DON) and the rest of the Quality Assurance Committee on the QA regulation. The education included problem identification, solutions follow up and revisions of same if needed. 2. Between June 29 - July 1, 2011 all the employees were re-educated on the QA Process, revised policy and guidelines by the Director of Nurses, Administrator and/or designee. The education included QA access, meeting attendance, and etc. 3. On June 3, 2011 the Administrator, Director of Nurses (DON) and Clinical Nurse Consultant (CNC) reviewed and revised the QA policy. The Medical Director reviewed and approved the revised QA policy and guidelines on June 3, 2011. Between June 29 - July 1, 2011 a post-test was required of all employees to ensure understanding of the QA process. The QA process addresses and will address standards of practice the facility staff is to follow on diverse topics. Audits will be conducted by diverse departments and from that audit Conclusions will be made by the auditor. If no problems are identified then no recommendations or actions will be taken, but the report will be		

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F 520	<p>Continued From page 21</p> <p>plans of action to correct identified quality deficiencies. There was no evidence the facility Quality Assurance Committee identified that CMT #1 was not knowledgeable and competent regarding the facility policy to disinfect blood glucose monitoring devices between each resident use. The facility Quality Assurance Committee failed to identify and correct quality deficiencies related to disinfecting blood glucose monitors according to manufacturer's guidelines. In addition, the facility's failure to monitor the effectiveness of the training regarding the blood glucose monitoring policy and failure to monitor to ensure staff competency placed residents at risk for serious injury, harm, impairment, or death. (Refer to F441 and F490.)</p> <p>The findings include:</p> <p>A review of the facility infection control policies for transmission based precautions with a revised date of June 2010 revealed the policy had no guidance for quality assurance to monitor staff usage of equipment to prevent the risk for transmission of infectious bloodborne pathogens.</p> <p>On May 31, 2011, CMT #1 was observed to obtain residents #3, #16, and #17's blood sugar and clean the machine between each resident use with an alcohol wipe instead of the Super Sani-Cloth Germicidal Wipe as required by facility policy.</p> <p>An interview conducted with the Infection Control Nurse (ICN) on June 2, 2011, at 3:16 p.m., revealed the infection control nurse was required to monitor staff for competency regarding the use of equipment; however, there was no guidance</p>	F 520	<p>presented at the QA meetings as designated by the Committee. If problems or concerns are noted on the analysis of the collected data, then that is what Conclusion the auditor will bring forward to weekly, monthly and/or quarterly QA meeting (as designated by QA Committee). The auditor will make Recommendations and the QA Committee will make recommendations for actions/interventions to resolve the identified problem/concern. These actions/interventions should be placed in a priority sequence and put in place by responsible person/department. The QA Committee will determine frequency of re-audits and/or follow ups needed based on severity of problems/concerns identified. Dependent upon concerns/problems identified the auditor will report findings at Monday - Friday QA meeting, weekly QA meeting, monthly QA meeting and /or quarterly QA meeting.</p> <p>4. The CNC will review with the Administrator the QA Committee agenda, action plans, monitoring audits, and the revision of the action plans if so identified to ensure the facility is appropriately engaged in the QA process with the administrator monthly for the next three months.</p>	7/01/11	

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F 520	<p>Continued From page 22</p> <p>from the quality assurance committee regarding the procedure for the monitoring of staff to ensure that all staff was competent after the facility staff received training on the change of the cleaning policy for the blood glucose monitor (BGM). According to the ICN, in-services were conducted for all staff who utilized the BGM on February 15, 2011 and March 1, 2011. A review of the in-service minutes revealed 13 staff members were trained on February 15, 2011, and 10 staff members were trained on March 1, 2011. Further interview revealed the in-services were often conducted on the spot with each staff member and the staff would often be distracted during the in-service. Review of the ICN audits for competency of use and disinfecting of the BGMS revealed competency was reviewed for three staff members; however, an audit was not completed for CMT #1 to ensure competency of the policy for disinfecting the BGMS between resident use.</p> <p>Quality Assurance (QA) interviews conducted with the Administrator and Director of Nursing (DON) on June 2, 2011, from 6:15 p.m. to 6:45 p.m., revealed the facility conducted a monthly QA meeting to identify concerns. The interview revealed infection control was a part of QA and the role of infection control in QA was defined by the Centers for Disease Control (CDC) Guidelines. Further interview with the Administrator and the DON revealed the QA Committee was not aware of any concerns regarding staff competency of cleaning BGMS according to the new policy. In addition the QA Committee was not aware that monitoring of staff competency after a policy change was not being completed systematically to ensure that all staff</p>	F 520			

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F 520	<p>Continued From page 23 was competent in the cleaning/disinfecting of the BGMs between resident use.</p> <p>**An acceptable Allegation of Compliance was received on June 3, 2011, which alleged removal of Immediate Jeopardy on June 4, 2011. An extended survey was conducted on June 7, 2011, which determined the Immediate Jeopardy was removed on June 4, 2011. A review of the Allegation of Compliance and verification revealed the following:</p> <p>A review of the facility policy for Quality Assurance revealed the policy was revised on June 3, 2011, with provisions for monitoring staff competency related to in-service training and the cleaning/disinfecting of BGMs.</p> <p>Observations and interviews conducted on June 7, 2011, from 12:30 to 4:00 p.m., with CMTs, LPNs, and RNs who performed blood glucose monitoring for residents revealed the staff had been trained by the facility and competency established by return demonstration on the facility's blood glucose monitoring policy. Observations conducted on June 7, 2011, from 12:30 to 4:00 p.m., revealed LPN and RN staff demonstrated proper technique for blood glucose monitoring according to the facility's policy and procedure and CDC guidelines when obtaining the resident's blood glucose.</p> <p>A review of in-service documentation revealed an in-service was conducted with the QA committee on June 3, 2011, by the Clinical Nurse Consultant regarding identification of problems/issues, development of actions plans, monitoring the action plan, review of the monitoring results, and</p>	F 520		

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F 520	<p>Continued From page 24</p> <p>revision of the action plans if noncompliance issues were still present.</p> <p>A review of QA Committee meeting minutes revealed that the QA Committee had met on June 3, 6, and 7, 2011, to review and monitor the facility ongoing interventions for appropriate use of BGMs between residents and for signs and symptoms of infection for all residents who could have been affected by the inappropriate disinfection of the BGMs between resident use by CMT #1.</p> <p>Interviews conducted with the Administrator and the Director of Nursing on June 7, 2011, from 5:15 to 6:30 p.m., revealed the CNC had in-serviced the facility QA Committee to monitor the infection control program for quality deficiencies and develop plans of action to address the quality deficiencies. Further interview revealed the plans of action would be evaluated for effectiveness. Further interview revealed the in-services for QA would be extended to all staff.</p> <p>Based on the above findings, it was determined the Immediate Jeopardy was removed on June 4, 2011. Noncompliance continued with scope and severity lowered to "D" based on the facility's need to evaluate the effectiveness of CQI activities related to the implementation of Policies and Procedures for the Infection Control Program and the QA Committee's oversight and monitoring of the Infection Control Program for quality deficiencies.</p>	F 520			

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on June 1, 2011. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). Christian Health Center was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview, the facility failed to ensure a weekly written maintenance schedule was being performed on the emergency generator. This deficient practice affected seven of seven smoke compartments, staff, and all the residents. The facility has the capacity for 115 beds with a census of 98 on the day of the survey. The findings include: During the life safety code tour on June 1, 2011,	K 000	Preparation or 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.		
K 144 SS=F		K 144	K 144 1. The weekly inspection and maintenance of the generator was conducted on June 22, 2011 and will continue weekly thereafter. 2. The administrator reviewed the inspection log from June 22, 2011. No problems were identified during this inspection. Between February 2011 and June 22, 2011 there had been no problems with the generator. 3. The Administrator reviewed and revised the policy and procedure related to the weekly generator inspection. Maintenance staff will conduct the following checks of the generator weekly: disconnects labeled and accessible, generator locked and tagged out, battery disconnected, belts tight and checked for wear and alignment, oil level at proper fill, coolant level at proper fill,		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Bill Collins* TITLE Administrator (X6) DATE 7/1/11

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.

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K 144	<p>Continued From page 1</p> <p>at 9:10 a.m., an interview with Maintenance staff revealed the generator was not being maintained on a weekly basis as required. The Maintenance staff person stated the Director of Maintenance had been off for a while and the weekly maintenance to the generator had been overlooked since February 2011.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p>	K 144	<p>battery connections clean, free of corrosion, battery cells full, unit checked for water leaks, fuel leaks, and oil leaks, block heater on and working, make up air vents clear, free from blockage and storage, make up air dampers operational, clock timer working and accurate, generator area free of overgrown weeds and shrubs, generator room free of storage, adequate supply of spare parts in stock, oil, antifreeze, distilled water, spark plugs. The Administrator conducted a re-education session with the maintenance department that included the the weekly inspection of the generator. The Administrator explained the importance of the required testing/inspection.</p> <p>4. The maintenance staff will inspect the generator weekly per the guidelines in number 1 above. The Maintenance Supervisor, or designee, will report any identified problems with the generator promptly to the Administrator. The Administrator will conduct a QA Audit weekly for one month, then every two weeks for one month for the next 2 months to ensure the maintenance staff is in compliance with the generator exercises and will submit these findings to the QA Committee monthly for two months then as directed by the QA Committee.</p>	7/1/11	