



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

PRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/25/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
(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 241	<p>Continued From page 1</p> <p>Depression, and Multiple Sclerosis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/11/14, revealed the facility assessed the resident as frequently incontinent of bladder and requiring extensive assistance with dressing and toileting. In addition, the facility assessed the resident's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of "08" which indicated the resident was interviewable.</p> <p>Observation and interview with Resident #1, on 02/23/15 at 1:09 PM, revealed he/she had difficulty communicating and using the call light.</p> <p>Interview, on 02/24/15 at 12:03 PM, with Resident #1's State Guardian revealed it was around 4:00 PM on 01/14/15, when she saw Resident #1 up in his/her wheelchair and the resident's gray sweat pants were visibly wet, and smelled of urine. She stated CNA #1 and #2 informed her they could not change the resident as the mattress pad cover was in the laundry. The State Guardian stated she made the Activities Director and Social Service Director aware of the resident being wet and she left the facility at about 4:35 PM. "</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 02/23/15 at 1:15 PM, revealed she assisted Resident #1 up in the wheelchair at 11:00 AM that morning. CNA #4 stated she provided the resident incontinent care and put on a clean brief and clothes prior to getting Resident #1 up.</p> <p>Interview with CNA #2, on 02/23/15 at 2:15 PM, revealed Resident #1 had told her he/she was waiting to go back to bed but the resident's mattress pad cover was in the laundry. CNA #2</p>	F 241	<p>4. The Director of Nursing, Unit Manager or Weekend Nurse Supervisor will make observations of all residents' appearance 5 x per week for 12 weeks to ensure residents are clean, dry and groomed appropriately, that staff are providing the necessary assistance for activities of daily living and that if a resident's room is unavailable the staff are using an alternate location. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Activity Director Maintenance Director with the Medical Director attending at least quarterly.</p>	3/26/15	

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

PRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/25/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
--	--

(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 241	<p>Continued From page 2</p> <p>stated her and CNA #1 had told the Guardian they would put the resident back to bed when the mattress pad cover got dry. CNA #2 stated the Guardian told them she was on her way up front to tell someone Resident #1 was wet and needed changing. CNA #2 revealed at the time it was not her end of the hall and she had to go to the dining room. CNA #2 revealed she did not know they could take the resident to the shower room to change or to another empty room.</p> <p>Interview with CNA #1, on 02/23/15 at 2:00 PM, revealed when she came on shift at 2:00 PM, Resident #1's mattress pad cover was in the laundry and Resident #1 was up in his/her wheelchair. CNA #1 revealed she did not know Resident #1 was wet and she did not know when Resident #1 was put back to bed. CNA #1 stated she was just assisting on that hall until CNA #3 got back.</p> <p>Interview with CNA #3, on 02/23/15 at 2:40 PM, revealed he came on duty at 2:00 PM. He stated when he went to Resident #1's room, he asked why the mattress cover was off and was told it was in the laundry. He stated he told CNA #2 he had to go to Administrator's office, and left around 3:00 PM. He revealed the Administrator told him his residents would be covered and CNA #1 was sent over to cover while he was gone. He stated Resident #1 was up in the wheelchair and was dry when he left; however, when he returned at 5:30 PM-6:00 PM, Resident #1 was still up in the wheelchair and was soaking wet. CNA #3 stated the mattress cover was back on the bed so he placed a clean draw sheet on the bed and got someone to assist him in putting Resident #1 in bed.</p>	F 241		
-------	---	-------	--	--

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

PRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/25/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286	
(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 241	<p>Continued From page 3</p> <p>Interview, on 02/25/15 at 9:08 AM with Licensad Practical Nurse (LPN) #3, revealed Resident #1 had told her he needed to be changed and wanted to go back to bed. LPN #3 stated she had to go to the Administrator's office, and did not tell anyone the resident wanted to be changed and go back to bed. LPN #3 revealed she saw no one to tell and "I did not go in the rooms looking for them". The LPN stated she last saw Resident #1 at 3:00 PM that day (01/14/15).</p> <p>Interview, on 02/23/15 at 2:55 PM with the Social Services Director (SSD), revealed CNA #1 and CNA #2 were not aware that if a mattress pad cover was not on the bed, they could use alternative measures to change the resident. The SSD stated Resident #1's Guardian approached her around 2:30 or 3:00 PM to tell her Resident #1 was wet. The SSD revealed the Guardian reported to her that CNA #1 and CNA #2 were asked to change the resident and the CNAs replied they could not change the resident because the mattress pad cover was in the laundry.</p> <p>Interview on 02/23/15 at 3:05 PM with the Activities Director revealed Resident #1's Guardian told her around 4:00 PM that Resident #1 was wet, and wanted her to find a CNA. The Activities Director stated she asked CNA #1, and she said it was not her resident; then asked CNA #2 who said "okay, okay, I know" and then informed her that she could not change the resident and put him back to bed because the mattress pad cover was in the laundry. The Activities Director revealed after talking to CNA #2 she went to the dining room.</p> <p>Interview, on 02/23/15 at 3:42 PM, with Director</p>	F 241		

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

PRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/25/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
(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 241	Continued From page 4 of Nursing (DON) revealed she knew about the incident with Resident #1 after it happened. The DON stated she did immediately provided education about alternate means of changing residents. The DON revealed she "spot questionad" other staff members and they were aware of the need to tall their charge nurse and find another means of changing a resident. The DON stated CNA #1 and #2 were not aware of being able to change in another way, and she did not know why they did not know and others did. The DON stated there was an empty bed in Resident #1's room that could have been used to change the resident.	F 241			
F 282 SS=D	483.2D(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 interview, record review and review of the facility's policy, it was determined the facility failed to ensure staff provided care for one (1) of three (3) sampled residents (Resident #1) in accordance with the written Plan of Care (POC) related to incontinent care.  The findings include:  Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included, Anxiety State, Multiple Sclerosis, Diabetes, After NOS, Hypertension, Esophageal	F 282			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/25/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42296		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 5</p> <p>Reflux, Chronic Pain, Cerebral Vascular Accident(CVA), Wound Disruption, Depression, and Edema. Review of the Resident #1 Quarterly Minimum Data Set (MDS) assessment, dated 11/11/14, revealed Resident #1 was assessed as being always incontinent of bowel and frequently incontinent of bladder, requiring extensive assistance for toileting and personal hygiene, extensive assistance for bed mobility and dressing, was at risk of developing pressure ulcers related to history of pressure and incontinence.</p> <p>Review of the Comprehensive Care Plan, last updated 02/09/15, revealed the resident was care planned for risk for skin breakdown related to impaired mobility and incontinence and Self Care Deficit related to needing extensive assistance with Activities of Daily Living(ADL'S). Interventions in place were to provide incontinent care as needed.</p> <p>Interview, on 02/24/15 at 12:03 PM, with Resident #1's State Guardian revealed it was around 4:00 PM on 01/14/15, when she saw Resident #1 up in his/her wheelchair and the resident's gray sweat pants were visibly wet, and smelled of urine. She stated CNA #1 and #2 informed her they could not change the resident as the mattress pad cover was in the laundry. The State Guardian stated she made the Activities Director and Social Service Director aware of the resident being wet and she left the facility at about 4:35 PM. "</p> <p>Interview on 02/23/15 at 2:15 PM with CNA #2, revealed Resident #1 had told her he/she was waiting to go back to bed but the resident's mattress pad cover was in the laundry. CNA #2 stated her and CNA #1 had told the Guardian</p>	F 282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN</p> <ol style="list-style-type: none"> <li>1. The Director of Nursing on 2/26/15 reviewed resident # 1's care plans and observed resident # 1 and their environment to determine if all care planed interventions were in place. No concerns were identified.</li> <li>2. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Nurse Supervisor, Activity Director, Social Services Director, Dietary Manager and MDS Nurse will review all current resident's care plans to determine if all care plan interventions are in place. This will be completed by 3/3/15 and any identified interventions not in place will be immediately put in place.</li> <li>3. The Director of Nursing, Unit Manager, Nurse Supervisor or MDS Nurse will educate all nursing staff on following the plan of care to include if a nursing assistant is unable to follow the plan of care they must report to the nurse for further direction. If a licensed nurse is unable to follow the plan of care and they cannot alter the plan of care within their scope of practice they are to notify the physician. This education will be completed by 3/25/15 with no nursing staff working after 3/25/15 without having had this education.</li> <li>4. The Director of Nursing or MDS Nurse will observe and audit five residents and their medical records weekly for twelve weeks to determine if care plan interventions are</li> </ol>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/26/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 6</p> <p>they would put the resident back to bed when the mattress pad cover got dry. CNA #2 stated the Guardian told them she was on her way up front to tell someone Resident #1 was wet and needed changing. CNA #2 revealed at the time it was not her end of the hall and she had to go to the dining room. CNA #2 revealed she did not know they could take the resident to the shower room to change or to another empty room.</p> <p>Interview with CNA #3, on 02/23/15 at 2:40 PM, revealed he came on duty at 2:00 PM and went to the Administrator's office around 3:00 PM. He stated he told CNA #2 he had to go to Administrator's office. He revealed Resident #1 was up in the wheelchair and was dry when he left; however, when he returned at 5:30 PM-6:00 PM, Resident #1 was still up in the wheelchair and was soaking wet.</p> <p>Interview, on 02/25/15 at 9:08 AM with Licensed Practical Nurse (LPN) #3, revealed Resident #1 had told her he needed to be changed and wanted to go back to bed. LPN #3 stated she had to go to the Administrator's office, and did not tell anyone the resident wanted to be changed and go back to bed. LPN #3 revealed she saw no one to tell and "I did not go in the rooms looking for them". The LPN stated she last saw Resident #1 at 3:00 PM that day (01/14/15).</p> <p>Interview, on 02/25/15 at 9:08 AM with Licensed Practical Nurse (LPN) #3, revealed Resident #1 had told her he needed to be changed and wanted to go back to bed. LPN #3 stated she had to go to the Administrator's office, and did not tell anyone the resident wanted to be changed and go back to bed. LPN #3 revealed she saw no one to tell and "I did not go in the rooms looking for</p>	F 282	<p>implemented. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Activity Director Maintenance Director with the Medical Director attending at least quarterly.</p>	3/26/15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/25/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 7 them". The LPN stated she last saw Resident #1 at 3:00 PM that day (01/14/15).  Interviews on 02/23/15 at 2:55 PM with the Social Services Director and at 3:05 PM, with the Activities Director, revealed Resident #1's Guardian had told them sometime between 3:00 PM and 5:00 PM that CNA #1 and CNA #2 had been asked to change the resident because he/she was wet and they had replied they could not change the resident because the resident's mattress pad was in the laundry and they could not lay the resident in the bed to change him/her. The Activities Director stated she asked CNA #1, and she said it was not her resident; then asked CNA #2 who said "okay, okay, I know".  Interview, on 02/23/15 at 3:42 PM, with Director of Nursing (DON) revealed she knew about the incident with Resident #1 after it happened. The DON stated CNA #1 and #2 were not aware of being able to change in another way, and she did not know why they did not know and others did. The DON stated there was an empty bed in Resident #1's room that could have been used to change the resident per the care plan.	F 282			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:	F 312			

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

PRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/25/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 8</p> <p>Based on observation, interview, and record review, it was determined the facility failed to provide incontinent care for one (1) of three (3) sampled residents (Resident #1), who was unable to carry out activities of daily living related to incontinent care.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Cerebral Vascular Accident, Anxiety, Depression, and Multiple Sclerosis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/11/14, revealed the facility assessed the resident as frequently incontinent of bladder and requiring extensive assistance with dressing and toileting. In addition, the facility assessed the resident's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of "08" which indicated the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan, last updated 02/09/15, revealed the resident was care planned for risk for skin breakdown related to impaired mobility and incontinence and Self Care Deficit related to needing extensive assistance with Activities of Daily Living (ADL'S). Interventions in place were to provide incontinent care as needed.</p> <p>Observation and interview with Resident #1, on 02/23/15 at 1:09 PM, revealed he/she had difficulty communicating and using the call light.</p> <p>Interview, on 02/24/15 at 12:03 PM, with Resident #1's State Guardian revealed it was around 4:00 PM on 01/14/15, when she saw Resident #1 up in</p>	F 312	<p><b>F 312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</b></p> <p>1. Incontinent care was provided for resident #1 by CNA #3 on 1/14/15 as observed by the Director of Nursing. On 1/15/15 the Director of Nursing observed that resident # 1 was receiving the necessary assistance for activities of daily living.</p> <p>2. The Director of Nursing observed all current residents on 1/15/15 and noted that all were clean, dry, well groomed and their dignity was being maintained and those that required assistance with activities of daily living received the assistance necessary. No concerns were identified.</p> <p>3. All Direct care staff including licensed nurses and nursing assistants will be re-educated by the Director of Nursing, Unit Manager, MDS Nurse or Administrator on maintaining resident dignity including maintaining a clean and groomed appearance and assistance with necessary activities of daily living this will be completed by 3/25/15</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 03/11/2015  
FORM APPROVED  
QMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/25/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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)	(X3) COMPLETION DATE	
F 312	Continued From page 9 his/her wheelchair and the resident's gray sweat pants were visibly wet, and smelled of urine. She stated CNA #1 and #2 informed her they could not change the resident as the mattress pad cover was in the laundry. The State Guardian stated she made the Activities Director and Social Service Director aware of the resident being wet and she left the facility at about 4:35 PM."  Interview with Certified Nursing Assistant (CNA) #4, on 02/23/15 at 1:15 PM, revealed she assisted Resident #1 up in the wheelchair at 11:00 AM that morning. CNA #4 stated she provided the resident incontinent care and put on a clean brief and clothes prior to getting Resident #1 up.  Interview with CNA #2, on 02/23/15 at 2:15 PM, revealed Resident #1 had told her he/she was waiting to go back to bed but the resident's mattress pad cover was in the laundry. CNA #2 stated her and CNA #1 had told the Guardian they would put the resident back to bed when the mattress pad cover got dry. CNA #2 stated the Guardian told them she was on her way up front to tell someone Resident #1 was wet and needed changing. CNA #2 revealed at the time it was not her end of the hall and she had to go to the dining room. CNA #2 revealed she did not know they could take the resident to the shower room to change or to another empty room.  Interview with CNA #1, on 02/23/15 at 2:00 PM, revealed when she came on shift at 2:00 PM, Resident #1's mattress pad cover was in the laundry and Resident #1 was up in his/her wheelchair. CNA #1 revealed she did not know Resident #1 was wet and she did not know when Resident #1 was put back to bed. CNA #1 stated	F 312	4. The Director of Nursing, Unit Manager or Weekend Nurse Supervisor will make observations of all residents' appearance 5 x per week for 12 weeks to ensure residents are clean, dry and groomed appropriately, that staff are providing the necessary assistance for activities of daily living and that if a resident's room is unavailable the staff are using an alternate location. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Activity Director Maintenance Director with the Medical Director attending at least quarterly.	3/26/15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/25/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 10</p> <p>she was just assisting on that hall until CNA #3 got back.</p> <p>Interview with CNA #3, on 02/23/15 at 2:40 PM, revealed he came on duty at 2:00 PM. He stated when he went to Resident #1's room, he asked why the mattress cover was off and was told it was in the laundry. He stated he told CNA #2 he had to go to Administrator's office, and left around 3:00 PM. He revealed the Administrator told him his residents would be covered and CNA #1 was sent over to cover while he was gone. He stated Resident #1 was up in the wheelchair and was dry when he left; however, when he returned at 5:30 PM-6:00 PM, Resident #1 was still up in the wheelchair and was soaking wet. CNA #3 stated the mattress cover was back on the bed so he placed a clean draw sheet on the bed and got someone to assist him in putting Resident #1 in bed.</p> <p>Interview with CNA #5, on 02/24/15 at 9:08 AM, revealed she would go to her charge nurse if there was a problem with not being able to change a resident. The CNA stated she thought every CNA would know to go to their nurse and find another way to change if the resident's mattress pad cover was not available.</p> <p>Interview, on 02/25/15 at 9:08 AM with Licensed Practical Nurse (LPN) #3, revealed Resident #1 had told her he needed to be changed and wanted to go back to bed. LPN #3 stated she had to go to the Administrator's office, and did not tell anyone the resident wanted to be changed and go back to bed. LPN #3 revealed she saw no one to tell and "I did not go in the rooms looking for them". The LPN stated she last saw Resident #1 at 3:00 PM that day (01/14/15).</p>	F 312			

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

 PRINTED: 03/11/2015  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/25/2016
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	<p>Continued From page 11</p> <p>Interview, on 02/23/15 at 2:55 PM with the Social Services Director (SSD), revealed CNA #1 and CNA #2 were not aware that if a mattress pad cover was not on the bed, they could use alternative measures to change the resident. The SSD stated Resident #1's Guardian approached her around 2:30 or 3:00 PM to tell her Resident #1 was wet. The SSD revealed the Guardian reported to her that CNA #1 and CNA #2 were asked to change the resident and the CNAs replied they could not change the resident because the mattress pad cover was in the laundry.</p> <p>Interview on 02/23/15 at 3:05 PM with the Activities Director revealed Resident #1's Guardian told her around 4:00 PM that Resident #1 was wet, and wanted her to find a CNA. The Activities Director stated she asked CNA #1, and she said it was not her resident; then asked CNA #2 who said "okay, okay, I know" and then informed her that she could not change the resident and put him back to bed because the mattress pad cover was in the laundry. The Activities Director revealed after talking to CNA #2 she went to the dining room.</p> <p>Interview, on 02/23/15 at 3:42 PM, with Director of Nursing (DON) revealed she knew about the incident with Resident #1 after it happened. The DON stated she did immediately provided education about alternate means of changing residents. The DON revealed she "spot questioned" other staff members and they were aware of the need to tell their charge nurse and find another means of changing a resident. The DON stated CNA #1 and #2 were not aware of being able to change in another way, and she did not know why they did not know and others did.</p>	F 312		

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

PRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/25/2015
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 12 The DON stated there was an empty bed in Resident #1's room that could have been used to change the resident.	F 312	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.		