

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

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/02/2015
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey Investigating Complaint KY#22971 was conducted on 03/31/15 through 04/02/15. KY#22971 was substantiated with deficiencies cited at the highest Scope and Severity of a "D".</p> <p>F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of hospital records, review of the facility policy and procedure, and review of the Lippincott Manual Nursing Practice #8, it was determined the facility failed to ensure services provided met professional standards of care related to an assessment for one (1) of three (3) sampled residents (Resident #1). Licensed Practical Nurse (LPN) #1, failed to conduct a head to toe skin assessment of Resident #1 prior to transferring the resident from the floor to the chair after the resident sustained a fall on 02/24/15. The resident was transferred to the hospital on 02/24/15 and was diagnosed with a fractured left femur.</p> <p>The findings include: Review of the Lippincott Manual Nursing Practice Eighth Edition, revealed a complete assessment should be performed after a resident has fallen. Review of the facility's Fall policy, dated 06/2013,</p>	F 000	<p>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *James M. Marko* TITLE *Administrator* (X6) DATE *5/01/15*

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 281	<p>Continued From page 1</p> <p>revealed the charge nurse should evaluate the resident after a fall occurs for any signs and symptoms of injury. Further review revealed a completed Incident report must be completed and the Unit Manager and Director of Nursing will review for accuracy.</p> <p>Review of the facility's "Quick and Easy Head to Toe Physical Examination", not dated, revealed the lower extremity assessment should include an observation of the extremities for symmetry, muscle tone, movement, bruising and skin alterations. In addition, the joints must be palpated for tenderness and to determine if active range of motion can be performed.</p> <p>Record review revealed the facility admitted Resident #1 on 12/08/14 with a diagnoses which included Hypertension (HTN), Dementia, Hypothyroidism, Joint Disorder, Depression, Glaucoma, Stroke, Malaise and Fatigue, Left Femur Fracture, History of Falls, Cognition Communication Deficit and Muscle Weakness.</p> <p>Review of the Nursing Notes, dated 02/24/15 at 10:37 PM, revealed Licensed Practical Nurse (LPN) #1 and a student placed Resident #1 back in the recliner after finding Resident #1 on the floor between the chair and the bed. She stated that the resident told her he/she was attempting to hang up his/her coat but did not have a coat or sweater. She then palpated her head and performed a neurological check and obtain vital signs while he/she was lying on the floor. She pull the resident's pant legs up to knee and saw no bruising but never palpated the resident's lower extremities. The resident stated he/she was hurting in the left thigh area.</p>	F 281	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Resident #1 was transferred to the hospital (03/06/15) and did not return to this facility.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents who have a fall will have a head to toe assessment completed by a licensed nurse prior to being moved.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Incident/Event Investigation Form was revised 4/21/2015 by Director of Nursing to include Head to toe Assessment to be checked on Preliminary Actions Taken review. (Exhibit 1)</p> <p>Director of Nursing and/or Director of Clinical Services provided education with return demonstration of Quick Head to Toe Assessment for all Licensed Nurses. (4/2-4/3/2015)</p>	5/01/15

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F 281	<p>Continued From page 2</p> <p>Interview with LPN #1, Charge Nurse, on 04/04/15 at 8:30 AM, revealed on 02/24/15 she was down the all when student nurses stated that the call light of Resident #1 was on. LPN #1 stated the two (2) student nurses went into Resident #1's room and found the resident on the floor between the chair and the bed. LPN #1 revealed the resident stated he/she was attempting to hang up his/her coat and fell. LPN #1 stated she immediately palpated the resident's head and conducted a neurological check and obtained vital signs while the resident was lying on the floor. LPN #1 revealed she asked the resident if he/she was having pain and the resident replied yes in the left thigh and pointed there. LPN #1 stated she pulled the resident's pant legs up to knee and saw no bruising but stated she never palpated the resident's lower extremities for deformities or checked the resident's pulses. LPN #1 stated she lifted Resident #1's upper body and someone else lift the resident's legs and placed the resident back in the recliner. LPN #1 revealed when they moved the resident he/she yelled out with pain in the left thigh. LPN #1 stated stated that it never occurred to her to assess the thigh where the resident was complaining of pain. LPN #1 revealed she did not palpate any part of lower body during her assessment. LPN #1 stated while a Certified Nurse Aide (CNA) stayed with the resident she attempted to call the doctor twice and left a message because she wanted to obtain orders. LPN #1 revealed the physician called back and gave orders for Mobile X-ray however, the family had arrived and requested that the resident be transported to the hospital by ambulance. LPN #1 stated the ambulance was called and when the Ambulance arrived they cut the resident's pants away from the left thigh area</p>	F 281	<p>Director of Nursing and/or Unit Managers provided education for all licensed nurses on:</p> <p>a) Charting/Documentation of falls including assessment and monitoring (3/31 – 4/3/15)</p> <p>b) Policy & Procedure regarding Incidents/Accidents and revised form.</p> <p>Director of Nurses and/or Unit Managers provided education for all staff on Fall policy and procedures.</p>	

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F 281	Continued From page 3 and noted she had a broken femur. LPN #1 revealed the ambulance attendants applied traction after moving the resident onto the stretcher which provided the resident some relief from the pain. Review of the local hospital record, dated 2/24/15, revealed the resident was diagnosed with left femur fracture and was transferred to a larger hospital for a higher level of care and surgical repair of the fractured femur. Interview on 03/31/15 at 11:36 AM with Registered Nurse (RN) #1, RN #2 and RN #3 revealed when a resident sustains a fall an assessment should be conducted by the charge nurse prior to moving the resident and vital signs should be obtained at that time. Interview with the Director of Nursing (DON), on 03/31/15 at 2:57 PM, revealed the charge nurse should have assessed the resident from head to toe and assessed where the resident complained he/she had pain immediately. The DON stated the staff should have provided care if need and the physician and family/POA/Guardian should be notified. She stated the staff not assessing the resident prior to moving the resident could have caused harm to the resident. Interview with the Physician, on 03/31/15 at 2:45 PM, revealed she would have expected the resident to have been assessed head to toe prior to moving the resident.	F 281	How does the facility plan to monitor its performance to ensure that solutions are sustained? Fall Committee Monitoring form was revised 4/21/2015 by Fall Committee and review of Event Investigation for Accuracy/Completeness was added. (Exhibit 2) Fall Committee (including, Director of Nursing, Staff Development Coordinator, Administrator, Unit Manager, Therapy and other members of Interdisciplinary Care Team as needed) will report compliance and results to QA team (including Director of Nursing, Staff Development Coordinator, Social Services Director, Human Resources, Dietary Manager, Environmental Services Supervisor, Maintenance Supervisor, Medical Director, Office Manager, MDS Coordinator, Medical Records Supervisor and Chaplain) monthly for 6 months or upon recommendation of QA committee. The Director of Nursing is responsible for follow up and recommendations.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309			

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F 309	<p>Continued From page 4</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, Prehospital Care Report, review of hospital records and review of the facility's policy and procedures it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of three (3) sampled residents (Resident #1). Resident #1 sustained a fall on 02/24/15 and complained of pain to the left thigh area. Licensed Practical Nurse (LPN) #1 failed to conduct a head to toe assessment to include the resident's thigh prior to transferring the resident from the floor to the chair. Resident #1 was sent to the hospital and diagnosed with a left femur fracture.</p> <p>The findings include:</p> <p>Review of the Lippincott Manual Nursing Practice Eight Edition revealed a complete assessment should be performed after a resident has fallen.</p> <p>Review of the facility's fall policy, dated 06/2013, revealed the charge nurse should evaluate the resident after a fall occurs for any signs and</p>	F 309	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Resident #1 was transferred to the hospital (03/06/15) and did not return to this facility.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents who have a fall will have a head to toe assessment completed by a licensed nurse prior to being moved.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Incident/Event Investigation Form was revised 4/21/2015 by Director of Nursing to include Head to toe Assessment to be checked on Preliminary Actions Taken review. (Exhibit 1)</p> <p>Director of Nursing and/or Director of Clinical Services provided education with return demonstration of Quick Head to Toe Assessment for all Licensed Nurses. (4/2-4/3/2015)</p>	5/01/15

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F 309	<p>Continued From page 5</p> <p>symptoms of injury. Additionally, a completed incident report must be completed and the Unit Manager and Director of Nursing will review the for accuracy.</p> <p>Review of the facility's "Quick and Easy Head to Toe Physical Examination" revealed the lower extremity assessment included to observe the extremities for symmetry, muscle tone, movement, bruising and skin alterations. The joints should be palpated for tenderness and active range of motion can be performed.</p> <p>Record review revealed the facility admitted Resident #1 on was admitted on 12/08/14 with a diagnoses to include Hypertension (HTN), Dementia, Hypothyroidism, Joint Disorder, Depression, Glaucoma, Stroke, Malaise and Fatigue, Left Femur Fx, History of Falls, Cognition Communication Deficit and Muscle Weakness. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/13/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status score of seven (7) which indicated the resident was not interviewable. In addition, the resident was assessed as requiring extensive assistance with one person assist with ambulation and transferring and had a history of falls.</p> <p>Review of the Comprehensive Care Plan for risk for injury, with a goal date of 04/21/15 revealed intervention for resident to have a bed alarm and chair alarm, to not leave the resident alone in bathroom and to ensure walker is in reach except when in bed.</p> <p>Review of the Nursing Note, dated 02/24/15 at 10:37 PM, revealed Resident #1 was found on</p>	F 309	<p>Director of Nursing and/or Unit Managers provided education for all licensed nurses on:</p> <p>a) Charting/Documentation of falls including assessment and monitoring (3/31 – 4/3/15)</p> <p>b) Policy & Procedure regarding Incidents/Accidents and revised form.</p> <p>Director of Nurses and/or Unit Managers provided education for all staff on Fall policy and procedures.</p>		

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F 309	<p>Continued From page 6</p> <p>the floor between his/her bed and chair. Licensed Practical Nurse (LPN) #1 and a student placed Resident #1 back in the recliner. Further review revealed the LPN palpated the resident's head and performed a neurological check and obtained vital signs while the resident was lying on the floor. The note revealed the LPN pulled the resident's pant legs up to knee and saw no bruising. Further review revealed the told the nurse he/she was hurting in the left thigh area.</p> <p>Review of the Prehospital Care Report from the Ambulance, dated 2/24/15 at 2:45 PM, revealed they were called to facility for a resident that had fallen. It was noted Resident #1 was lying in a recliner and their assessment noted the left leg was shortened and rotated to the inside. The documentation revealed they placed the resident on a sheet and placed him/her on the stretcher. The report revealed they applied traction to the leg and the resident stated it felt better. They transferred the resident to local hospital.</p> <p>Review of the local hospital record, dated 2/24/15, revealed the resident was diagnosed with left femur fracture and was transferred to a larger hospital for a higher level of care and surgical repair of the fractured femur.</p> <p>Interview with LPN #1, Charge Nurse, on 04/04/15 at 8:30 AM, revealed on 02/24/15 two (2) student nurses went into Resident #1's room and found the resident on the floor between the chair and the bed. LPN #1 stated she immediately palpated the resident's head and conducted a neurological check and obtained vital signs while the resident was lying on the floor. LPN #1 revealed she asked the resident if he/she was having pain and the resident replied</p>	F 309	<p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Fall Committee Monitoring form was revised 4/21/2015 by Fall Committee and review of Event Investigation for Accuracy/Completeness was added. (Exhibit 2)</p> <p>Fall Committee (including, Director of Nursing, Staff Development Coordinator, Administrator, Unit Manager, Therapy and other members of Interdisciplinary Care Team as needed) will report compliance and results to QA team (including Director of Nursing, Staff Development Coordinator, Social Services Director, Human Resources, Dietary Manager, Environmental Services Supervisor, Maintenance Supervisor, Medical Director, Office Manager, MDS Coordinator, Medical Records Supervisor and Chaplain) monthly for 6 months or upon recommendation of QA committee. The Director of Nursing is responsible for follow up and recommendations.</p>	

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F 309	<p>Continued From page 7</p> <p>yes in the left thigh and pointed there. LPN #1 stated she pulled the resident's pant legs up to knee and saw no bruising but stated she never palpated the resident's lower extremities for deformities or checked the resident's pulses. LPN #1 stated she lifted Resident #1's upper body and someone else lift the resident's legs and placed the resident back in the recliner. LPN #1 revealed when they moved the resident he/she yelled out with pain in the left thigh. LPN #1 stated stated that it never occurred to her to assess the thigh where the resident was complaining of pain. LPN #1 revealed she did not palpate any part of lower body during her assessment. LPN #1 revealed the physician called back and gave orders for Mobile X-ray however, the family had arrived and requested that the resident be transported to the hospital by ambulance. LPN #1 stated the ambulance was called and when the Ambulance arrived they cut the resident's pants away from the left thigh area and noted she had a broken femur. LPN #1 revealed the ambulance attendants applied traction after moving the resident onto the stretcher which provided the resident some relief from the pain.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 03/31/15 at 1:53 PM, revealed Resident #1 sustained a fall while she was at lunch. CNA #1 stated when she returned from lunch, Resident #1 was sitting in the recliner crying and shaking so she remained with the resident until the ambulance arrived. CNA #1 revealed the resident's sons arrived at the facility approximately thirty (30) minutes after they were notified and the resident was complaining of pain the entire time from his/her knee to the thigh area. CNA #1 stated when the ambulance staff</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>arrived they cut the resident's pants off to assess the thigh area. CNA #1 revealed the resident's left leg appeared to be deformed and dipped down on the top and the ambulance staff placed a sheet under the resident and transferred the resident to the stretcher. CNA #1 stated the resident yelled out "That hurts" as they were transferring him/her to the stretcher. CNA #1 revealed when the sons came, they asked about how long the resident had been shaking and she informed the sons the resident had been shaking since the fall.</p> <p>Interview with LPN #2, on 03/31/15 at 2:30 PM, revealed LPN #1 told her that Resident #1 had fallen and she was waiting for the physician to call to get the order for the X-ray. LPN#2 stated she told LPN #1 not to move the resident and to leave the resident in the recliner because she was hurting. LPN #2 revealed the family arrived and requested that the resident be transferred to the Emergency Room by ambulance.</p> <p>Interview on 03/31/15 at 11:36 AM with Registered Nurse (RN) #1, RN #2 and RN #3 revealed when a resident sustains a fall an assessment should be conducted prior to moving the resident and that vital signs should be obtained at that time.</p> <p>Interview with the Director of Nursing (DON), on 03/31/15 at 2:57 PM, revealed the staff should have assessed the resident from head to toe and assessed where the resident complained he/she had pain immediately. The DON stated the staff should have provided care if needed and the physician and family/POA/Guardian should be notified. She stated the staff not assessing the resident prior to moving the resident could have</p>	F 308			

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F 309	Continued From page 9 caused harm to the resident. Interview with the Physician, on 03/31/15 at 2:45 PM, revealed she would have expected the resident to have been assessed head to toe prior to moving the resident.	F 309		