PRINTED: 04/30/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 185318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/31/2010
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE CENTER OF KUTTAWA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED An annual survey was conducted on 03/24-26/10. An extended survey was conducted on 03/29-31/10. Immediate Jeopardy was identified in the areas of 483.25, F323 S/S 'J' and 483.75, F490 S/S 'J' and SQC identified in the area of 483.25, F323 S/S 'J'. Immediate Jeopardy was determined to exist on 03/23/10. The facility was notified of the Immediate Jeopardy and SQC on 03/26/10. An acceptable AOC was received on 03/30/10, during the extended survey. Immediate Jeopardy was verified removed, effective 03/28/10, on 03/31/10, with the remaining noncompliance as follows: F323 and F490 at a S/S of 'D'.	F 000	Disclaimer for Plan of Correction Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Kuttawa of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Kuttawa files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/ Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for	F 156	**F 156** Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Residents The facility has re-investigated CMS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Adm. (X6) DATE 5/7/10

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 156	Continued From page 1 which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control	F 156	guidelines regarding notifying residents of non-coverage decisions, types of services that will be denied, and the demand billing process. The following has been noted: Beginning July 1, 2005, beneficiaries in Original Medicare were given access to a new fast-track expedited review process when Medicare coverage of their skilled nursing services are about to end. Skilled nursing facilities are required to notify individuals of this new Right when they anticipate that Medicare coverage of their services will end. The two notices associated with the implementation of these expedited reviews were published for comment in the Federal Register—the Notice of Medicare Provider Non-Coverage (Generic Notice) and the Detailed Explanation of Non-Coverage (Detailed Notice). Residents 19, 25, 26, 27 and 28 were all notified of pending discharge from Medicare and given the right to an appeal process according to CMS Instructions related to the Generic Notice and the Expedited Determination Process located at http://www.cms.gov/BNI/Downloads/CMS10123Instructions.pdf. These Instructions indicate, *"A Medicare provider must give a completed copy of this notice to beneficiaries receiving services from skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), or hospice not later than 2 days before the termination of services. This notice fulfills the requirement at 42CFR §405.1200(b). This is a standardized notice. Providers may not deviate from the content of the form except where indicated."*	

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F 156	Continued From page 2 unit, and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined, the facility failed to implement the requirements of the demand billing process regarding the omission of a paragraph that best	F 156	The requirements at 42 CFR §405.1200(b) indicate: *"Advance written notice of service terminations. Before any termination of services, the provider of the service must deliver valid written notice to the beneficiary of the provider's decision to terminate services. The provider must use a standardized notice, as specified by CMS..."* The CMS guidelines instructing on the use of this notice (the Generic Notice) do not indicate a requirement to notify the resident of the types of services that were going to be denied. In fact, the instructions indicate, regarding the Additional Information space on page two of the Generic Notice, *"This space is available, at the option of the provider to furnish additional relevant information to the beneficiary, such as further details about the reason for the service termination..."* The expedited determination process concludes after the issuance of the Generic Notice, if the resident does not ask for a review of the facility's non-coverage decision by the QIO. If the resident does indeed request a review by the QIO, according to the CMS guidelines, the facility is then required to issue the Detailed Notice of Non-Coverage, noted above, indicating, *"The detailed explanation of why the services are no longer covered under Medicare."* These instructions may be found at http://www.cms.gov/BNI/Downloads/CMS10124Instructions.pdf. None of the residents in the noted sample requested a review of the facility's non-coverage decision by the QIO, therefore, Detailed Notices were not issued.	

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F 156	Continued From page 2 unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined, the facility failed to implement the requirements of the demand billing process regarding the omission of a paragraph that best	F 156	The expedited determination process, noted above, is not meant to facilitate the submission of a demand bill to the MAC on the beneficiary's behalf. Rather, it allows for an expedited review process that is facilitated by the QIO. The process that would initiate a demand bill is facilitated by the issuance of one of the SNF Notices of Non-Coverage or the SNF ABN, form CMS-10055. CMS guidelines at CMS Publication 100-4 Ch. 30 §70.4.4.3, governing this process, specifically the use of the SNF ABN, indicate that *"If the patient selects Option 1, the patient may receive the subject extended care items or services, for which a demand bill must be submitted to Medicare for an official determination."* However, these same guidelines at §70.6.7 indicate that, *"Medicare never pays for extended care items or services not ordered by a physician. No SNF ABN is needed when extended care items or services are reduced or terminated in accordance with a physician's order, where a physician does not order the items or services at issue..."* Residents 19, 25, 26, 27 and 28 were never notified of facility's non-coverage decision and the demand billing process was not implemented via the SNF ABN, because the skilled services being delivered were reduced and/or terminated in accordance with a physician order. As is noted above, all were appropriately notified of the facility's non-coverage decision via the expedited determination process with the Generic Notice. However, in order to comply with the stated deficiency, Residents 19, 25, 26, 27 and 28	

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F 156	Continued From page 2 unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined, the facility failed to implement the requirements of the demand billing process regarding the omission of a paragraph that best	F 156	have all been re-notified via an amended Generic Notice, Form CMS-10123, of the types of services that were going to be denied coverage. Identification of Other Residents with Potential to be Affected In order to comply with the stated deficiency, the MDS Coordinator has identified all current residents receiving Medicare Part A services and has identified all of the skilled services that are currently being delivered. For each of these residents, the interdisciplinary team, made up of the Director of Nursing, Administrator, MDS Nurse, Director of Social Services, and Rehabilitation Services Director, will meet daily to review determination as to when these services will no longer be covered by Medicare. The Social Services staff, as part of this team, will be made aware of these determinations and will be prepared to notify these residents of the facility's non-coverage decision, along with his or her right to the appeal process. Systematic Changes In order to comply with the stated deficiency, the facility has revised its policy and procedure regarding notification of non-covered Part A services to reflect the use of additional information space on page 2 of the Generic Notice, Form CMS-10123, to note the types of services that the facility has determined to be non-covered under Medicare coverage guidelines and which the facility expects to be denied coverage.	

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F 156	Continued From page 2 unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined, the facility failed to implement the requirements of the demand billing process regarding the omission of a paragraph that best	F 156	The MDS Coordinator will keep up-to-date records identifying all current residents receiving Medicare Part A services, as well as all of the skilled services that are currently being delivered. For each of these residents, the interdisciplinary team, made up of the Director of Nursing, Administrator, MDS Nurse, Director of Social Services and Rehabilitation Services Director, will continue to meet daily to review determinations as to when these services will no longer be covered by Medicare. The Social Services staff, as part of this team, will be made aware of these determinations and will be prepared to notify these residents of the facility's non-coverage decision, along with his or her right to the appeal process via the Generic Notice. <u>Monitoring</u> The Administrator will use the "Medicare Part A Non-Coverage Decision Notification Audit" as a tool to audit each Medicare Part A Discharge on a monthly basis to determine if compliance with facility policy and procedure has been maintained regarding appropriate notification of facility non-coverage decisions. The audit will determine: 1. That appropriate notification was given. 2. If the appropriate appeal process and/or demand billing process was implemented. These findings will be reported at the monthly Performance Improvement Committee meeting and deficiencies will be	

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F 156	Continued From page 3 non-covered. Five residents (#19, #25, #26, #27 and #28), not in the selected sample, were not informed of the types of services that were going to be denied coverage, prior to the services being discontinued, to enable the residents' rights to the appeals process. Findings include: A review of the five most recent denial notices issued to beneficiaries revealed all five notices stated the provider had determined that Medicare probably would not pay for the residents' skilled nursing and/or rehabilitation services after a certain date. Four of the five reviews did not include the reason for the denial or what services were being discontinued. Resident #19's record included the fact the resident was discharged from therapy due to the resident having met all of the goals set. However, the information did not include what therapy (physical therapy, speech therapy, etc) was being discontinued. An interview, on 03/26/10 at 8:40 AM, with the Business Office Manager, revealed the Social Services Director, who was a former employee sent out the forms to the residents. However, the Business Manager was in charge of the process currently and was not aware a reason had to be specified on the form. There had been no requests for demand billing since the last survey.	F 156	followed up by the Director of Social Services. The Performance Improvement Committee consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Assessment Nurse, Maintenance Director, Activities Director, Social Services Director, Medical Records Clerk, Human Resources Clerk, Housekeeping/Laundry Supervisor, Therapy Manager, and Dietary Manager.	4-14-10
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician	F 157	**F 157** Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

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F 157	Continued From page 4 intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.10(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to immediately notify and consult with the resident's physician regarding a significant change of condition and/or failed to ensure orders were obtained for two residents (#4 & #13), in the selected sample of 15. Resident #4 was admitted to the facility after a hip fracture. The facility failed to assess the resident to determine the type and severity of the pain	F 157	Corrective Actions for Targeted Residents The attending physician for Resident #4 was notified and an order for a new pain regimen was obtained on 3/26/10. Resident #4 was re-assessed on 3/27/10 and the new pain medication order was found to be effective. Resident #13 was placed on comfort measures and expired on 3/25/10. Identification of Other Residents with Potential to be Affected Due to the nature of this practice, current residents in the facility could be affected. Systematic Changes Licensed Nurses will be educated by the Director of Nursing on or before 4/9/10 regarding notification of MD with any resident change of status. Education of Licensed Nurses will also include the importance of physician contact in a timely manner, even if multiple attempts are required. This will include notification of the Medical Director, if necessary. The Director of Nursing and Assistant Director of Nursing will review new orders daily to ensure that the MD was notified in a timely manner of any change of condition. The Director of Nursing will educate Licensed Nurses on or before 4/9/10 on how to fill out a 24-hour report sheet, including what information is pertinent for communication to the next shift, and to assist the DON or ADON with follow-up. The Director of Nursing or Assistant Director of Nursing will review the 24-hour report sheets on a daily	

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F 157	Continued From page 5 experienced by the resident and failed to notify and consult with the physician, obtain and administer the previously prescribed pain medications. The resident was not provided needed pain medication for a period of four days. Resident #13 experienced increased congestion and the inability to clear secretions resulted in a gurgling quality to the resident's voice. The facility failed to promptly notify the physician regarding the resident's symptoms and consult with the physician regarding the need for suctioning. The facility failed to follow its' established policies and procedures related to physician notification. Findings include: Review of the facility's Notification of Physician policy and procedure, dated 01/2000 and last revised 09/2008, revealed the facility was to promptly notify the resident's physician of changes in the resident's condition and/or status. Listed reasons for notifying the physician included a significant change, a need to alter the resident's treatment significantly. If the nurse was unable to contact the resident's attending physician, or the attending physician failed to respond within a reasonable amount of time and depending on the nature of the resident's condition, the Medical Director would be notified and informed of the resident's condition. The nurse recorded in the medical record any changes in the resident's condition and/or status, to include physician notification. A review of the facility policy and procedure, dated 11/1988, revised 11/2008 and 03/2010, related to Suctioning included procedures to	F 157	basis to ensure that physicians are notified of changes in a resident's condition in a timely manner. Internal protocols were established on 4/6/10, and approved by the Medical Director, to include an order to suction PRN with a yankauer. Licensed Nurses will be educated by the Director of Nursing on or before 4/9/10 on the internal protocols, which will include an order to suction PRN with a yankauer. Pain assessment will be conducted upon admission, PRN and quarterly. Continued monitoring of quarterly pain assessments will be done by the MDS Coordinator. Within 24 hours of admission, the DON, ADON or Weekend Supervisor will review the charts for completeness, with an emphasis on pain assessment. Any resident noted to have pain or a history of pain will trigger the DON, ADON, or Weekend Supervisor to insure that there are orders for pain control. If no orders are in place, the DON, ADON or Weekend Supervisor will contact the admitting MD for said orders. After two failed attempts within an hour and a half, the Medical Director will be contacted and the DON will be notified of this immediately. If the Medical Director is not reached after two attempts in an hour and a half, the resident will be transferred to the ER for evaluation and treatment of the pain. The Director of Nursing will be notified of the necessity of this transfer.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185318	A. BUILDING _____ B. WING _____	03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF KUTTAWA, LLC	1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055

(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 157	Continued From page 6 "Verify there is a physician's order for suctioning of the Resident, including route of suctioning (i.e., nasal or trach)". 1. Resident #4 was admitted to the facility from the hospital, on 12/05/09, with diagnoses including a Hip Fracture which could not be surgically repaired and Chronic Compression Fractures of the Lumbar Spine. Review of the admission nursing notes, dated 12/05/09 at 6:45 PM, revealed the resident was alert with confusion, had clear speech and was able to make his/her needs known. A review of the admission medication orders, dated 12/05/09, revealed orders included Percocet 5 mg by mouth every 6 hours for breakthrough pain and Fentanyl patch 50 mcg every 3 days. Review of a Change of Condition form, dated 12/09/09, revealed "Contacted MD office several times this shift and previous days for RX for Percocet and Fentanyl patch. Order received for Hydrocodone oral solution 7.5 milligrams (mg) for pain". Two prescriptions written by a physician for Fentanyl Transdermal 50 micrograms (mcg) every 72 hours and one for Percocet 5 mg every 6 hours for breakthrough pain were dated 12/09/09. The Admission Evaluation and Interim Care Plan, dated 12/05/09, revealed there was no documented evidence of a pain assessment in the designated section of the form. An interview with Licensed Practical Nurse (LPN) #1, on 03/25/10 at 9:45 AM, revealed Resident #4 was admitted on the weekend and attempts had been made to notify the resident's physician of the need to obtain a handwritten prescription for the narcotic medications, which were	F 157	Monitoring The Director of Nursing, Assistant Director of Nursing or House Supervisor will monitor new orders and 24-hour report sheets on a daily basis to ensure charge nurses are notifying physicians with changes in a resident's condition in a timely manner. The DON will report these findings to the Performance Improvement Committee for review and recommendations. This Committee consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Assessment Nurse, Medical Records, Housekeeping/ Laundry Director, Dietary Manager, Maintenance Director, Social Services Director, Human Resources, Activities Director, and Therapy Manager. The Director of Nursing will follow up on any recommendations made by the Committee.	4-14-10

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F 157	Continued From page 7 unsuccessful. The pharmacy required a handwritten prescription for the narcotics, prior to filling the prescription. LPN #1 had not documented evidence of a pain assessment and exactly how many and when attempts had been made to notify the physician. A nurse who no longer worked at the facility had completed a portion of the Admission Evaluation and Interim Care Plan on 12/05/09, but did not document the results of a pain assessment in the designated area on the form. Interview with LPN #1 revealed Resident #4 "verbalized pain", but the resident's physician was difficult to contact and although attempts had been made, the attempts were not documented. LPN #1 stated no attempts were made to notify the Medical Director, when the attempts to contact the resident's physician failed. Interviews with the Director of Nursing (DON), on 03/25/10 at 3:10 PM and on 03/29/10 at 9:30 AM, revealed she had not been made aware Resident #4 did not receive his/her pain medication, until 12/09/09, which was four days after the resident was admitted to the facility. The DON verified the facility had experienced difficulty with contacting some physicians, but staff should have notified the Medical Director. An interview with Resident #4's physician, on 03/26/10 at 4:10 PM, revealed he would have expected Resident #4 to experience pain with a hip fracture, and would have also expected staff to notify the Medical Director, in the event he could not be reached, to obtain needed pain medications. Observation on 03/24/10 at 11:25 AM, revealed	F 157		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 157	Continued From page 8 Resident #4 was in bed with oxygen per nasal cannula. The resident stated he/she had pain most of the time, but the pain was better than it was on admission to the facility. The resident also revealed he/she was not sure if he/she had been given anything for pain. The resident was observed on 03/25/10 at 9:10 AM, yelling out in pain and was heard at 10:15 AM telling a Certified Nurse Aide (CNA) he/she had pain. 2. Resident #13 was admitted to the facility with diagnoses to include Advanced Alzheimer's Disease and Arthritis. A review of the significant change assessment/RAPS, dated 12/17/09, revealed he/she was alert with confusion, had contractures to both hands and required maximum assistance with all activities of daily living. The resident had behaviors of cursing staff and demanding to go home which were not easily redirected. All needs were anticipated by staff. On 03/25/10, during the lunch meal (exact time not documented), a Speech Therapist determined the resident was not safe for PO (by mouth) intake due to increased congestion, inability to clear and increased gurgling quality to the resident's voice. The Speech Therapist spoke with LPN #1 and recommended an order for suctioning. LPN #1 made two attempts to contact the physician for a suction order, without success, and told LPN #3 before leaving for the day at 2:00 PM. LPN #3 contacted the physician's "nurse" for a "comfort measures" order sometime after her arrival at 2:00 PM. Neither nurse documented attempts to contact the physician for any orders on 03/25/10. An interview with LPN #1 on 03/30/10 at 10:10	F 157		

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F 157	Continued From page 9 AM revealed he had attempted to notify Resident #4's physician sometime around lunch time without success and made another attempt before leaving for the day but got a recording the office was out for lunch and he did not leave a message. He did not attempt to contact the Medical Director when the resident's physician could not be contacted. LPN #1 did not suction Resident #4 because no order had been obtained and he would not suction without an order. LPN #1 felt it was not an emergency. An interview with LPN #3 on 03/29/10 at 3:30 PM revealed she had been made aware of LPN #1's attempts to notify the physician for suction orders and assessed Resident #13 after she came on duty at 2:00 PM on 03/25/10. LPN #3 stated the resident was not "gurgling" but had labored respirations and spoke with the physician's "nurse" and obtained a "comfort measures" order. LPN #3 did not document any notification or order because, "It was hectic and I just didn't get it done". Additionally, LPN #3 did not provide any suctioning for Resident #4. An interview with Resident #13's physician on 03/26/10 at approximately 2:30 PM, revealed he would expect nurses to provide suctioning to a resident if they thought it was needed and if it was urgent a resident should be sent to the emergency room. The physician recalled something about a suction order for Resident #13 but could not remember anything specific. The physician stated suctioning might have made Resident #13 more comfortable.	F 157		
F 160 SS=B	483.10(c)(8) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund	F 160	**F 160** Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

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F 160	Continued From page 10 deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined, the facility failed to ensure the accounts of three residents, (#29, #30 and #31), not in the selected sample, were properly accounted and dispersed within 30 days of the resident's death. Findings include: 1. A record review revealed Resident #29 expired on 08/31/09. The resident's account was not reconciled and the check for the balance sent to the beneficiaries until 11/2/09. 2. A record review revealed Resident #30 expired on 01/20/10. The resident's account was not reconciled until 03/25/10. 3. A record review revealed Resident #31 expired on 06/01/09. The resident's account was not reconciled until 12/02/09. An interview with the Business Office Manager on 03/26/10 at 8:50 AM, revealed she was aware of the need to close the residents' accounts within 30 days. However, the facility was bought out by a corporation in April 2009 and the manager stated due to the need to complete much paperwork for the transition, some paperwork (the accounts) fell behind in completion.	F 160	Corrective Actions for Targeted Residents The facility's Business Office Manager refunded Resident #29 on 11/20/09; #30 on 3/25/10; and #31 on 12/2/09. The Business Office Manager will refund discharged resident accounts within 30 days of discharge. The Business Office Manager reviewed all trust accounts on 3/29/10 and found no trust account refunds of discharged residents past due. Identification of Other Residents with Potential to be Affected The facility's Business Office Manager will identify potential residents that would be affected by the same practice by use of trust account software which generates a report identifying discharged residents' trust accounts that are due refunds within 30 days of discharge. Systematic Changes The facility Business Office Manager will review the resident trust accounts daily, including reviewing the trust account software-generated reports that identify resident trust account balances of discharged residents, date of discharge, and compare against refunds to assure compliance of refunds within 30 days of discharge. Any refunds due will be refunded within 30 days of discharge. Monitoring The Administrator will review monthly the resident trust accounts to identify dis-	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	charged resident trust account balances	

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F 160	Continued From page 10 deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined, the facility failed to ensure the accounts of three residents, (#29, #30 and #31), not in the selected sample, were properly accounted and dispersed within 30 days of the resident's death. Findings include: 1. A record review revealed Resident #29 expired on 08/31/09. The resident's account was not reconciled and the check for the balance sent to the beneficiaries until 11/2/09. 2. A record review revealed Resident #30 expired on 01/20/10. The resident's account was not reconciled until 03/25/10. 3. A record review revealed Resident #31 expired on 05/01/09. The resident's account was not reconciled until 12/02/09. An interview with the Business Office Manager on 03/26/10 at 8:50 AM, revealed she was aware of the need to close the residents' accounts within 30 days. However, the facility was bought out by a corporation in April 2009 and the manager stated due to the need to complete much paperwork for the transition, some paperwork (the accounts) fell behind in completion.	F 160	to assure the refunds are sent within 30 days of discharge. Findings of these audits will be reported to the facility's Performance Improvement Committee for review and recommendations. The Committee, which meets monthly, consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Assessment Nurse, Medical Records, Housekeeping/ Laundry Director, Dietary Manager, Maintenance Director, Social Services Director, Human Resources, Activities Director, and Therapy Manager. The Administrator and Business Office Manager will follow up on any recommendations of this Committee.	4-15-10
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=G	Continued From page 11 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined the facility failed to provide the necessary care and services for one resident (#4) in the selected sample of 15. The facility failed to ensure the nursing assessment/pain management policy and procedure was implemented. Resident #4 was admitted to the facility from the hospital with a fractured hip. Pain medications were ordered; however, the facility failed to assess for pain and failed to obtain and administer the prescribed medications for four days. The facility also failed to conduct ongoing pain assessments in an effort to manage Resident #4's ongoing pain. Findings include: Resident #4 was admitted to the facility from the hospital on 12/05/09 with diagnoses including a Hip Fracture, which could not be surgically repaired, and Chronic Compression Fractures of the Lumbar Spine. Nursing notes, dated 12/05/09 at 6:45 PM, revealed on admission the resident was alert with confusion, had clear speech and was able to make his/her needs known. Review of the medical record revealed the facility completed an Admission Evaluation and Interim	F 309	**F 309** Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Residents Resident #4 was re-assessed by the Director of Nursing and a new pain medication order was received on 3/26/10. Resident #4 was re-assessed again on 3/27/10, and the new pain medication order was found to be effective. Identification of Other Residents with Potential to be Affected Residents in the facility that coded for pain on the RAI assessments for the past 30 days were re-assessed for pain on 3/27/10 by the Director of Nursing and Registered Nurse. Pain assessments were completed on all remaining residents by 4/14/10. Systematic Changes Within 24 hours of admission, the Director of Nursing, Assistant Director of Nursing, or Weekend Supervisor will review the charts for completeness with an emphasis on the pain assessment. Any resident noted to have pain or a history of pain will trigger the DON, ADON or Weekend Supervisor to ensure that there are orders	

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	185316	A. BUILDING _____ B. WING _____	03/31/2010

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F 309	Continued From page 12 Care Plan on 12/05/09 for Resident #4; however, the pain section of the evaluation was blank. The facility could provide no evidence that they had assessed Resident #4 for pain. Review of the admission Medication Orders, dated 12/05/09, included Percocet 5 mg by mouth every 6 hours for breakthrough pain and Fentanyl Patch 50 mcg every 3 days. An interview with a family member, on 03/26/10 at approximately 4:30 PM, revealed Resident #4 had pain on admission due to a broken hip. An interview with Certified Nurse Aide (CNA) #3, on 03/25/10 at approximately 10:15 AM, revealed when the resident was admitted in December the pain was bad at first and then seemed better for awhile, but now he/she seemed more uncomfortable. An interview with CNA/Restorative Aide #5, on 03/25/10 at approximately 10:25 AM, revealed the pain the resident experienced upon admission was much worse than now. An interview with CNA #4, on 03/25/09 at approximately 4:15 PM, revealed Resident #4 complained of pain and stated the resident would complain that "it hurts" when touching him/her. An interview, conducted on 03/25/09 at approximately 2:35 PM with LPN #3, revealed Resident #4 "wouldn't move because he/she was in pain" when first admitted. Review of the medical record revealed between 12/05/09 and 12/08/09 there was no evidence that the facility conducted a pain assessment of resident #4 or attempted to contact the Medical Director when the resident's primary physician and on-call physician failed to respond and pain medications could not be obtained. Further review revealed the facility completed a Change in Condition form, dated 12/09/09, which detailed	F 309	for pain control. If no orders are in place, the DON, ADON, or Weekend Supervisor will contact the admitting MD. After two failed attempts within an hour and a half, the Medical Director will be contacted and the DON will be notified of this immediately. If the Medical Director is not reached after two attempts in an hour and a half, the resident will be transferred to the ER for evaluation and treatment of the pain. The DON will be notified of the necessity of this transfer. Pain assessment will be conducted upon admission, on any-one who has a significant change in pain, and quarterly. Continued monitoring of the quarterly pain assessments will be done by the MDS Coordinator. Licensed Nurses will be educated by the Director of Nursing on or before 4/9/10 on the following issues: the appropriate times to assess and re-assess a resident for pain; documentation of the pain assessment; the importance of physician contact in a timely manner, even if multiple attempts are required; documentation of all attempts; notification of the Medical Director if necessary; the requirement that the nurses document pain issues on the 24-hour report for communication to the next shift; and to assist the DON in follow up. Monitoring The Director of Nursing or Assistant Director of Nursing will audit 10% of the residents for pain weekly times four weeks, then monthly to ensure charge nurses are	

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F 309	Continued From page 13 "Contacted MD office several times this shift and previous days for RX for Percocet and Fentanyl patch. Order received for Hydrocodone oral solution 7.5 milligrams (mg) for pain". Two prescriptions were written by a physician for Fentanyl Transdermal 50 micrograms (mcg) every 72 hours and one for Percocet 5 mg every 6 hours for breakthrough pain were dated 12/09/09. Interviews with Licensed Practical Nurse (LPN) #1, on 03/25/10 at approximately 9:45 AM and on 03/26/10 at 9:10 AM, revealed Resident #4 was admitted on the weekend and the LPN and others had tried to contact the physician and the on-call physician about the pain medication for Resident #4. The resident had "verbalized pain". The physician's orders for the Fentanyl patch and the Percocet were scheduled narcotics which required a handwritten prescription before the Pharmacy would fill them. LPN #1 further revealed that he had not documented the resident's pain or conducted a pain assessment and was unable to verify exactly how many attempts were made to notify the physician to obtain the handwritten prescriptions. The LPN stated there was an on call physician for every weekend and they were to be called if the primary physician could not be contacted. The facility's Medical Director was also supposed to be contacted in the event the other physicians could not be reached. LPN #1 stated he did not attempt to call the Medical Director related to Resident #4's pain medications and should have. Interviews with the Director of Nursing (DON), on 03/25/10 at 3:10 PM and on 03/29/10 at 9:30 AM, revealed she was not aware Resident #4 had not received medication for pain until 12/09/10, which	F 309	obtaining physician orders in a timely manner for residents experiencing pain, and that the appropriate documentation is present. Any non-compliance noted will be addressed immediately by the DON or ADON per facility policy. The DON will report findings to the Performance Improvement Committee for review and recommendations. Any non-compliance will be referred back to the DON for immediate corrections. The Performance Improvement Committee meets monthly and consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Assessment Nurse, Medical Records, Housekeeping/ Laundry Director, Dietary Manager, Maintenance Director, Social Services Director, Human Resources, Activities Director, and Therapy Manager.	4-14-10

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F 309	Continued From page 14 was four days after the resident's admission. The DON also stated there were problems with contacting some physicians but staff should have notified the Medical Director. An interview was conducted, on 03/25/10 at approximately 11:45 AM, with the Minimum Data Set (MDS) Coordinator. She revealed residents were to be screened for pain upon admission, quarterly and/or when there was a significant change. The MDS Coordinator revealed she was responsible to ensure the pain assessments were completed and had somehow missed Resident #4's assessment. She was unaware the pain assessment had not been completed. A Pain Flow Sheet should have been implemented to monitor the resident's pain if a pain assessment had been completed. Resident #4 was not assessed for pain and a Pain Flow Sheet was not initiated. An interview with Resident #4's physician, on 03/26/10 at 4:10 PM, revealed he would have expected Resident #4 to have pain with a hip fracture but would have also expected staff to notify the Medical Director if they couldn't contact him. An observation, on 03/24/10 at 11:25 AM, revealed Resident #4 was in bed with oxygen per nasal cannula in place. The resident stated he/she had pain most of the time but the pain was better than it was on arrival to the facility. The resident also revealed he/she had been given medication but was not sure if he/she had been given anything for pain. Observations on 03/25/10 at 9:10 AM, revealed Resident #4 was in bed and yelling "oh, oh, oh, somebody help me". The resident could be heard down the hall. At	F 309		

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F 309	Continued From page 15 10:15 AM the resident was observed telling a Restorative Aide he/she had pain. Further review of the medical record revealed there was no evidence that the facility had conducted a pain assessment for Resident #4; even though, facility staff members: Nurse Aide (CNA) #3, and CNA/Restorative Aide #5 were aware of the resident's continued complaints of pain since 12/09/09. A review of the policy and procedure for Pain Management, dated 06/2002, and reviewed 09/2008, revealed all residents were to be initially screened for pain upon admission, quarterly and/or with a significant change in condition. A pain intensity scale (0-5) and the Wong-Baker Faces Pain Rating Scale was to be used to identify the resident's pain status and course of action required. A pain assessment was not completed for Resident #4 until 03/28/10, after surveyor questioning.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure adequate supervision to prevent accidents	F 323	**F 323** Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> Resident #11 was found and returned to the facility within five minutes of exiting the facility. Resident #11 was assessed and was found to have no injuries.	

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	186318	A. BUILDING _____ B. WING _____	03/31/2010

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F 323	Continued From page 16 was provided for one resident (#11) in the selected sample of 15. The facility failed to ensure its' "Missing Resident" and "Elopement Prevention" policies were effectively implemented for the assessment and identification of residents requiring supervision due to risk of elopement, the actual provision of supervision to ensure the safety of the residents and training of all staff responsible for ensuring the safety of the residents. Additionally, the facility failed to have a system developed and implemented that ensured residents requiring supervision were provided the necessary supervision when the Wanderguard alarm sounded at the exit door on the 100 hall and no resident was observed at the exit door on the 100 hall. On 03/23/10, resident #11 exited the 100 hall door of the facility with the alarm sounding and with his/her Wanderguard in place on his/her ankle without supervision for 400 feet from the facility. The resident was found walking on a public road, behind the facility with deep embankments, filled with large rocks, about 100 feet from the lake and there was no speed limit posted. The facility was unaware the resident had eloped. Three Certified Nurse Aides (CNA) #1, #2, and #3, were providing care for another resident in room #447 on hall 400, when one CNA looked out the window and saw the resident outside, unsupervised. On 03/25/10, Immediate Jeopardy (IJ) was identified at 483.25 at F323 at a S/S of "J" with substandard quality of care and at 483.75 at F490. The Immediate Jeopardy was determined to exist on 03/23/10. The facility was notified on	F 323	A new Missing Resident/Door Alarm policy was initiated on 3/25/10. On 3/26/10, 3/27/10, and 3/28/10, staff was inter-viewed by the DON and ADON regarding their knowledge and compliance with the new Missing Resident/Door Alarm policy. The Maintenance Director checked the Wander Prevention Alarm System by using an alarm testing device on 3/23/10, and the system was found to be functioning properly. The DON and ADON conducted resident elopement drills on 3/27/10 and 3/28/10. Results of the drills revealed that the staff was in compliance with the policy and procedures for elopements, missing residents, and door alarms. Identification of Other Residents with Potential to be Affected On 3/27/10, Elopement Assessments were conducted on current residents by the Director of Nursing and Registered Nurse to identify anyone at risk. No additional elopement risk residents were discovered. Systematic Changes Prior to 3/23/10, the Wander Prevention (Code Alert) Alarm System was checked routinely three times per week by the Maintenance Director. Effective 3/23/10, the Wander Prevention Alarm System will be checked daily by the Maintenance Director or nurse manager/Weekend Ambassador on duty, via alarm testing devices.	

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F 323	Continued From page 17 03/26/10 and a partial extended survey was conducted 03/29-31/10. An acceptable AoC was received on 03/30/10. The IJ was verified removed on 03/28/10, as alleged in the AOC, with continuation of the non-compliance at a scope and severity of a "D". The facility was notified on 03/31/10. Findings include: A review of the facility's Elopement Policy, dated March 2008, revealed the facility was to complete an Elopement Risk Assessment on admission for residents with a wandering history or potential. A care plan was to be implemented with interventions to stop or curtail the elopement behavior. An electronic sensing device (Wanderguard bracelet) or measures to monitor elopement attempts would be implemented. Should a resident actually elope, staff would follow the "Missing Resident" protocol immediately. A review of the facility's Missing Resident policy, dated September 2008, revealed staff were to report a suspected missing resident to the person in charge immediately, the person in charge would assemble all staff and inform them of the missing resident emergency. A search team would be formed for each wing of the building, if the resident was not found, the search outside the facility would be implemented. Review of the facility policy revealed no procedures for staff to follow immediately, when an alarm sounded and the cause of the alarm was not observed, to ensure all residents were safe. A record review revealed Resident #11 was admitted to the facility, on 03/19/10, with diagnoses which included Chronic Liver Disease.	F 323	The Missing Resident Policy was updated on 3/26/10 to include actions to be taken by staff upon hearing a door alarm, including staff going to the door emitting the alarm and going outside the building and searching the entire property for missing residents. They will also immediately conduct a resident head count to assure all residents are accounted for. On 3/26/10, current employees were in-serviced by the Director of Nursing and Assistant Director of Nursing on the new Missing Resident/Door Alarm policy prior to the shift commencement. New employees will be oriented by the DON or ADON on the Missing Resident/Door Alarm policy prior to being allowed to work. In addition, staff will be in-serviced two times per year by the DON/ADON regarding the Missing Resident/Door Alarm policy. Beginning 3/26/10, the DON and ADON will complete audits for compliance by inter-viewing staff regarding their knowledge of and compliance with the new Missing Resident/Door Alarm policy. Staff will be required to understand and explain the proper procedures in this policy. Effective 3/26/10, resident elopement drills will be conducted by the DON and ADON at least two times per year. Any non-compliance with the policy will be addressed immediately by the DON or ADON. Elopement assessments will be completed on admission, and upon a change in mental or physical status of the resident.	

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F 323	Continued From page 18 Cirrhosis Alcohol induced, Anemia and Alcohol Dependence. A review of an elopement assessment, dated 03/19/10, revealed the facility assessed the resident as an elopement risk due to a cognitive impairment with poor decision-making skills, the resident had verbally expressed a desire to go home, was observed lingering near exit doors, was recently admitted and the family/responsible party had voiced concerns that indicated the resident might attempt to leave the facility. A review of the interim care plan, dated 03/19/10, revealed Resident #11 was assessed and identified at risk for elopement and required the use of a Wanderguard. A review of a physician's order, dated 03/2010, revealed the facility applied the code bracelet (Wanderguard) to Resident #11's ankle due to wandering behaviors and risk for elopement. A review of the Nurse's Notes, dated 03/23/10 at 1:30 PM, revealed Resident #11 was observed walking outside on facility grounds unaccompanied by staff. The resident was calmly brought back in facility by staff members. An interview with Resident #11, on 03/26/10 at 9:00 AM, revealed she had no recall of exiting the facility alone. An interview with Housekeeper #1, on 03/26/10 at 10:00 AM, revealed on 03/23/10 at approximately 1:15 PM, she was supervising residents in the smoke lobby and heard the exit door alarm for the 100 hall sound. She waited one to two minutes and the alarm continued sounding. Housekeeper	F 323	Monitoring Beginning 3/26/10, the DON and ADON will complete audits for compliance by inter-viewing staff regarding their knowledge of and compliance with the new Missing Resident/Door Alarm policy. Findings of the monthly audits and semi-annual drills will be reported to the facility's Performance Improvement Committee for review and recommendations. The Committee meets monthly and consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Assessment Nurse, Medical Records, Housekeeping/ Laundry Director, Dietary Manager, Maintenance Director, Social Services Director, Human Resources, Activities Director, and Therapy Manager. The Maintenance Director will follow up on the Committee's recommendations.	4-14-10

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F 323	Continued From page 19 #1 asked Housekeeper #2 to supervise the smoking residents and she checked the exit door alarm on 100 hall. She looked out the door window and did not see anyone outside the door. She looked out two adjacent room windows and did not see anyone outside and disengaged the alarm and returned to the smoke area, without reporting the incident to any other staff. An interview with Housekeeper #2, on 03/26/10 at 11:40 AM, revealed she heard the alarm on hall 100 sounding for approximately five to 10 minutes. Housekeeper #1 requested she stay in the area with the residents smoking while she checked on the door alarm. An interview with Licensed Practical Nurse (LPN) #2, on 03/26/10 at 11:30 AM, revealed she worked on the 300 hall the day of the incident, and heard the alarm sound at the 100 hall exit door. She went to the 100 hall exit door and observed Housekeeper #1 leaving the area. The alarm was disengaged, by the housekeeper. LPN #2 stated she rechecked the area, looked out the front doors and asked Housekeeper #1 if she had seen anyone go outside. There was no further actions taken to ensure all residents were safe inside the building. An interview with CNA #1, on 03/26/10 at 10:00 AM, revealed CNA #1, #2 and #3 were in room #447, on 03/23/10 at approximately 1:30 PM, performing bed checks. CNA #1 looked out the window and observed a person's head moving along the ridge of the rocks and determined it was Resident #11 walking on the public road. CNA #1 and #2 exited out of the 500 hall exit door to approach and escort Resident #11 back inside the building. CNA #1 stated she was unaware	F 323		

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F 323	Continued From page 20 Resident #11 had exited the building unsupervised, prior to observing the resident outside. An interview with CNA #2, on 03/26/10 at 11:00 AM, revealed she was in the process of obtaining vital signs for a resident in room #447 (bed two), looked out the window and observed Resident #11 outside the back of the building, walking unsupervised on the public road. CNA #2 and #1 exited through the 500 hall exit door to escort Resident #11 back inside the building. She heard the alarm sound at hall 500 exit door as Resident #11 entered the exit doorway. An interview with CNA #3, on 03/26/10 at 11:50 AM, revealed at approximately 1:00 PM she was assisting a newly admitted resident and observed a person's head outside the window of room #447. Resident #11 was observed outside on the public road behind the facility. CNA #3 stated she heard no alarms for any exit doors on any hall prior to the observation and was unaware Resident #11 was outside the facility unsupervised. CNA #1 and #2 exited the facility to approach Resident #11 and CNA #3 reported the resident's elopement to LPN #1, who was at the nurses station. The alarm was heard as Resident #11 re-entered the building. An interview with LPN #1, on 03/25/10 at 11:25 AM, revealed he saw CNAs #1 and #2 exit the 500 hall exit door and he followed them. Resident #11 was found outside of the building on the public road unsupervised. CNA #1 escorted Resident #11 back inside the building through the 500 hall exit door and the alarm sounded. LPN #1 assisted Resident #11 to the front of the building and checked the front door alarm and the	F 323		

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F 323	Continued From page 21 Wanderguard on Resident #11 and the door was functioning properly. LPN #1 stated he heard no alarm, prior to the discovery of the resident outside the facility. An interview with the Assistant Director of Nursing (ADON), on 03/25/10 at 3:00 PM, revealed during orientation staff were trained to respond to the exit door alarms to look and see if a resident was near the door. If no resident was observed, the Charge Nurse was supposed to be notified and a head count of the residents would be performed to identify any missing residents. The ADON stated there was no policy in place at the time of the elopement on 03/23/10. An interview with the Director of Nursing (DON), on 03/26/10 at 1:50 PM, revealed the residents identified with wandering behaviors should have been accounted for when the alarm sounded at the exit door to assure all residents were safe, but this was not completed on 03/23/10, at the time of the elopement of Resident #11. An interview with the Administrator, on 03/26/10 at 3:30 PM, revealed he felt the policy worked, but changes would be made to the policy to assure safety and performance. A head count of the residents would be performed in the event a door alarm sounded and the reason was not obvious. He also stated he had only been employed at the facility four months and had not yet performed an elopement drill. During the extended survey, completed on 03/31/10, the facility provided an acceptable Allegation of Compliance (AoC), and alleged the Immediate Jeopardy was removed on 03/28/10.	F 323		

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F 323	Continued From page 22 Review of the AoC revealed the Director of Nursing and a Registered Nurse completed elopement assessments, on 03/27/10, for all residents to identify other residents at risk for elopement and found no additional residents were at risk for elopement. The Missing Resident/Elopement Policy was revised on 03/26/10 to include actions to be taken by staff upon hearing a door alarm, including staff going to the door emitting the alarm and going outside the building and searching the entire property for missing residents. They will also immediately conduct a resident head count to assure all residents are accounted for. The revisions to the facility's policy and procedures also included elopement assessments to be completed for residents on admission, quarterly and on an as needed basis. The updated "Missing Resident" policy and procedures were implemented on 03/26/10. Inservices regarding the revised procedures and staff responsibility related to the facility's "Missing Resident/Elopement" policies were completed on 03/26/10 by the Director of Nursing and the Assistant Director of Nursing. On 03/26/10 and 03/27/10, the DON and the ADON questioned the staff regarding their knowledge and understanding of the facility's policy and procedures. The DON and the ADON conducted elopement drills on 03/26/10 and 03/27/10, revealing staff compliance with the Missing Resident/Elopement policy and procedures. Effective 03/26/10 elopement drills will be conducted at least twice a year. Based on observations, interviews and record	F 323		

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F 323	Continued From page 23 reviews, it was determined the facility had removed the Immediate Jeopardy on 03/28/10. An observation conducted, on 03/30/10 at 3:30 PM, revealed Resident #11 was walking, with a purse in hand, and headed for Door #7 on the 500 wing roadside exit. The resident pushed on the door and the alarm sounded. The Maintenance Director immediately responded, along with three other staff members to assist the resident away from the door. At 3:40 PM, the resident again attempted to exit the facility through the courtyard doors and was intercepted by three staff members. The alarms were observed working properly and staff members responded effectively. An observation and demonstration of the door alarm system by the Maintenance Director, on 03/26/10 at 2:45 PM, revealed all six exit doors were equipped with 800 pound Meg-locks, Wanderguard sensors and a 15 second egress. All doors responded appropriately to the initiation of the Wanderguard sensor. Two courtyard doors, which were not connected into the Wanderguard system, had a separate alarm system. Code alert testing was completed on all exit doors, three times a week according to interviews with the Maintenance Director and a review of the Code Alert Check Sheet for January, February and March of 2010. The alarm check of the doors were completed daily since the elopement, and was included as part of the removal of Immediate Jeopardy. Reviews of the clinical records of Residents #7, #13 and #16, the three residents who were identified at risk for wandering, revealed Residents #7 and #13 were no longer at the	F 323		

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F 323	Continued From page 24 facility. Resident #16 was no longer a wandering risk, due to declining health, and was receiving Hospice care. The Wanderguard had been discontinued. The Risk of Elopement Reviews and a Summary of the Reviews were completed on 03/26-27/10 on Residents #16 and #7. Interviews conducted on 03/30-31/10 with staff members included: On the 10:00 PM until 6:00 AM shift; two LPNs, two CNAs and a housekeeper; On the 6:00 AM until 2:00 PM shift; five CNAs, two housekeepers, one RN, two LPNs, two therapists, and one MDS coordinator; On the 2:00 PM until 10:00 PM shift, three CNAs and the Activity Director were interviewed. All staff members expressed an understanding and working knowledge of the Missing Resident and Alarms Policies and all had been inserviced on 03/26-27/10. Review of the policies and procedures for "Missing Resident/Elopement Prevention", revised on 03/26/10, revealed specific procedures for staff to follow in the event a door alarm sounded and procedures for elopement risks assessments. A review of the Inservice Education Records, dated 03/26-27/10, revealed all staff members were inserviced regarding the facility policies and procedures for "Missing Resident/Elopement Prevention". A review of the documentation for two elopement drills on 03/27-28/10 revealed a resident "head count" was initiated and staff members responded appropriately. The remaining non-compliance at F323 at a S/S of a "D" was based on the facility's need to monitor for the ongoing effectiveness of its'	F 323		

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F 323	Continued From page 25 revised policies and procedures and to ensure the evaluation by the facility's Quality Assurance process.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to store food under sanitary conditions. An outdoor freezer was observed covered with large amounts of ice on the exterior door. A review of the Census and Conditions form dated 03/24/10, revealed the facility census was 67. It was determined 63 residents were served food stored and prepared in the facility kitchen. Findings include: An observation, on 03/24/10 at 7:40 AM, revealed the walk-in freezer, located outdoors behind the facility, had one to three inches of ice adhered to the outside bottom edges of the freezer door. Upon unlocking the door several inches of ice were observed on the floor and the inside edges of the freezer doorway. The plastic weather strips hanging inside the doorway were observed frozen	F 371	**F 371** Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Residents A new freezer door and proper sealing gasket were ordered on 4/14/10. The new door and proper sealing gasket will arrive from the manufacturer by 5/3/10. The freezer door manufacturer will install the new door and proper sealing gasket by 5/3/10. Identification of Other Residents with Potential to be Affected Current residents have the potential to be affected. Systematic Changes The freezer ice buildup was removed by the Dietary Manager on 3/26/10. Daily checks for ice buildup and removal will be conducted by the Dietary Manager and/or weekend supervisor to assure compliance. If any buildup occurs, it will be removed immediately by the Dietary staff and reported to the Maintenance Director for immediate review and necessary repair.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186318	A. BUILDING _____ B. WING _____	03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF KUTTAWA, LLC	1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055

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F 371	Continued From page 26 and caked with ice and the ice had to be broken away from the plastic strips, in order to access the inside of the freezer. Five of these weather strips remained frozen and stuck together. The light inside the freezer did not function and the glass cover for the light bulb was covered with ice. The ice had to be removed to access the fixture and replace the light bulb. The temperature inside was taken and registered -20 degrees Fahrenheit. One-half inch of frost crystals covered all the cardboard boxes containing food products in the freezer and also two plastic-wrapped pies and a tub of strawberry sherbet that were located on a shelf. Three to six inches of ice were observed on the feed cable to the light fixture. Six to eight inch icicles were observed hanging from the inlet cooling line and on the cooling system fans. An interview, on 03/24/10 at 7:50 AM, with the Maintenance Director revealed the freezer, which was several years old and was supposed to be an indoor freezer, was manually defrosted the previous week. The facility was aware of the problem and had stated to replace the freezer "at some time in the future". Part of the freezer's ice problem was due to the seal and sweeps, attached to the outside edges of the freezer door to prevent drafts, were getting iced-up and then ripped off when the door was opened.	F 371	The Maintenance Director will also conduct weekly checks on refrigerator and freezer doors and gaskets to assure they are functioning properly. Monitoring Findings of these reviews will be reported to the facility's Performance Improvement Committee which meets monthly and consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Assessment Nurse, Maintenance Director, Activities Director, Medical Records, Human Resources Clerk, Social Services Director, Housekeeping/ Laundry Supervisor, Dietary Manager and Therapy Manager. The Committee will review and give recommendations as necessary. Maintenance Director will follow-up per Committee's recommendations.	4-14-10
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.	F 490	**F 490** Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

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F 490	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility Administration failed to ensure the facility was administered in a manner that enabled it to use its' resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one resident (#11), in the selected sample of 15. The Administration failed to ensure policies and procedures were developed and/or implemented consistently and effectively related to supervision of residents at risk for elopement. The Administration failed to ensure its' staff was knowledgeable and trained regarding the facility's policies and procedures. The facility failed to provide adequate supervision for Resident #11, who the facility assessed as at risk for elopement and requiring supervision. Resident #11 eloped from the facility without staff knowledge and was found 400 feet from the facility, walking on a public road. On 03/26/10, Immediate Jeopardy (IJ) was identified at 483.25 at F323 at a S/S of "J" with Substandard Quality of Care and at 483.75 at F490 at a S/S "J". The Immediate Jeopardy was determined to exist on 03/23/10. The facility was notified on 03/26/10 and a partial extended survey was conducted 03/29-31/10. An acceptable AoC was received on 03/30/10. The IJ was verified removed on 03/28/10, as alleged in the AoC, with continuation of the non-compliance at a scope and severity of a "D". The facility was notified on 03/31/10. Findings include: On 03/26/10, Immediate Jeopardy (IJ) was	F 490	Corrective Actions for Targeted Residents Resident #11 was found and returned to the facility within five minutes of exiting the facility. Resident #11 was assessed and was found to have no injuries. A new Missing Resident/Door Alarm policy was initiated on 3/25/10. On 3/26/10, 3/27/10, and 3/28/10, staff was interviewed by the DON and ADON regarding their knowledge and compliance with the new Missing Resident/Door Alarm policy. The Maintenance Director checked the Wander Prevention Alarm System by using an alarm testing device on 3/23/10, and the system was found to be functioning properly. The DON and ADON conducted resident elopement drills on 3/27/10 and 3/28/10. Results of the drills revealed that the staff was in compliance with the policy and procedures for elopements, missing residents, and door alarms. Identification of Other Residents with Potential to be Affected On 3/27/10, Elopement Assessments were conducted on current residents by the Director of Nursing and Registered Nurse to identify anyone at risk. No additional elopement risk residents were discovered. Systematic Changes Prior to 3/23/10, the Wander Prevention (Code Alert) Alarm System was checked routinely three times per week by the Maintenance Director. Effective	

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CHRISTIAN CARE CENTER OF KUTTAWA, LLC	1283 LAKE BARKLEY DRIVE KUTTAWA, KY 42055

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F 490	Continued From page 28 Identified at 483.25 at F323 at a S/S of "J" with substandard quality of care and at 483.75 at F490 at a S/S "J". Based on observations, interviews and record reviews, it was determined the facility failed to ensure adequate supervision to prevent accidents was provided for Resident #11. The facility failed to ensure its' "Missing Resident", "Elopement", and "Door Alarms" policies were effectively implemented for the monitoring of the residents requiring supervision due to the risk of elopement, the actual provision of supervision to ensure the safety of the residents and the training of all staff responsible for ensuring the safety of the residents. These failures prevented the facility from ensuring appropriate supervision was provided for Resident #11. Resident #11 walked out the 100 hall door of the facility with the alarm sounding and with his/her Wanderguard in place on his/her ankle without supervision for 400 feet from the facility. The resident was found walking on a public road, behind the facility with deep embankments filled with large rocks, about 100 feet from the lake and there was no speed limit posted. The facility was unaware the resident had eloped. Three Certified Nurse Aides (CNA) #1, #2, and #3, were providing care for another resident in room #447 on hall 400, when one CNA looked out the window and saw the resident outside, unsupervised. (Refer to F323, Resident #11) Interviews with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN) #1, LPN #2, Housekeeper #1, Certified Nurse Aide (CNA) #2, and CNA #3, on 03/26/10 at 3:30 PM and 1:50 PM, on 03/25/10 at 3:00 PM and 1:00 PM, on 03/26/10 at 11:30 AM and 10:00 AM and record reviews, revealed there was no evidence	F 490	3/23/10, the Wander Prevention Alarm System will be checked daily by the Maintenance Director or nurse manager/Weekend Ambassador on duty, via alarm testing devices. The Missing Resident Policy was updated on 3/26/10 to include actions to be taken by staff upon hearing a door alarm, including staff going to the door emitting the alarm and going outside the building and searching the entire property for missing residents. They will also immediately conduct a resident head count to assure all residents are accounted for. On 3/26/10, current employees were in-serviced by the Director of Nursing and Assistant Director of Nursing on the new Missing Resident/Door Alarm policy prior to the shift commencement. New employees will be oriented by the ADON on the Missing Resident/Door Alarm policy prior to being allowed to work. In addition, staff will be in-serviced two times per year by the DON/ADON regarding the Missing Resident/Door Alarm policy. Beginning 3/26/10, the DON and ADON will complete audits for compliance by inter-viewing staff regarding their knowledge of and compliance with the new Missing Resident/Door Alarm policy. Staff will be required to understand and explain the proper procedures in this policy Effective 3/26/10, resident elopement drills will be conducted by the	

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CHRISTIAN CARE CENTER OF KUTTAWA, LLC	1261 LAKE BARKLEY DRIVE KUTTAWA, KY 42055

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F 490	Continued From page 29 staff had received any training on action to be taken after the exit door alarmed and the reason for the alarm was unknown. An Interview with the ADON, on 03/26/10 at 3:00 PM, revealed during orientation staff were trained to respond to the exit door alarms to look to see if any residents were observed. The ADON stated there was no policy in place at the time of the elopement, on 03/23/10, to ensure residents at risk for elopement were accounted for in the event an alarm sounded. An Interview with the DON, on 03/26/10 at 1:50 PM, revealed the residents identified with wandering behavior should have been accounted for when the alarm sounded at the exit door to assure all residents were safe, but this was not completed on 03/23/10, at the time of the elopement of Resident #11. During the partial extended survey, completed on 03/31/10, the facility provided an acceptable Allegation of Compliance (AoC), and alleged the Immediate Jeopardy was removed on 03/26/10. The AoC indicated Resident #11 was assessed for elopement tendencies. Resident #11 wore a transmitter bracelet that alarmed as he/she attempted to open the door. The "Missing Resident" policy was updated to include actions to be taken by staff upon hearing a door alarm. Staff are to go to the alarming door, go outside the building and search the entire property for missing residents. The staff are to immediately conduct a resident count to assure all residents are safe and accounted for. Staff were in-serviced, on 03/26/10, on the	F 490	DON and ADON at least two times per year. Any non-compliance with the policy will be addressed immediately by the DON or ADON. Elopement assessments will be completed on admission, and upon a change in mental or physical status of the resident. <u>Monitoring</u> Beginning 3/26/10, the DON and ADON will complete audits for compliance by inter-viewing staff regarding their knowledge of and compliance with the new Missing Resident/Door Alarm policy. Findings of the monthly audits and semi-annual drills will be reported to the facility's Performance Improvement Committee for review and recommendations. The Committee meets monthly and consists of the Medical Director, Administrator, Director of Nursing, Assistant Assessment Nurse, Medical Records, Housekeeping/ Laundry Director, Dietary Manager, Maintenance Director, Social Director of Nursing, Services Director, Human Resources, Activities Director, and Therapy Manager. The Director of Nursing will follow up on any recommendations of the Committee.	4-14-10

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F 490	Continued From page 30 revised "Missing Resident /Elopement Prevention" policies. All employees were in-serviced prior to shift commencement. The staff will be in-serviced two times a year regarding missing residents and the door alarms. Elopement Assessments were conducted on current residents, on 03/27/10, with no further residents identified at risk for elopement. The Elopement assessment will be conducted quarterly by the assessment nurse. In addition, the facility completed in-servicing regarding these changes on 03/28/10, to all staff members prior to shift commencement. Elopement drills were conducted on 03/27-28/10 to monitor the effectiveness of the training and a return demonstration of competency from staff members. The Wander Prevention Alarm System, which was monitored weekly by the Maintenance Director, is now scheduled to be monitored daily by the Maintenance Director or the nurse manager on duty. In addition, staff members were to be in-serviced two times a year, by the DON or ADON, regarding the Missing Resident and Door Alarm Policy. Based on observations, interviews and record reviews, it was determined the facility had removed the Immediate Jeopardy on 03/28/10. Reviews of the clinical records of Residents #7, #13 and #16, the three residents who were identified at risk for wandering, revealed Residents #7 and #13 were no longer at the facility. Resident #16 was no longer a wandering risk due to declining health, and received Hospice	F 490		

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F 490	Continued From page 31	F 490		

care. The Wanderguard had been discontinued. The Risk of Elopement Reviews and a Summary of the Reviews were completed on 03/26-27/10 on Residents #16 and #7.

A review of the Inservice Education Records, dated 03/26-27/10, revealed all staff members were inserviced. A review of the documentation for two elopement drills, on 03/27-28/10, revealed "head count" was initiated and staff members responded appropriately.

An observation and demonstration of the door alarm system, by the Maintenance Director on 03/26/10 at 2:45 PM, revealed all six exit doors were equipped with 800 pound Mag-locks, Wanderguard sensors and a 15 second egress. All doors responded appropriately to the initiation of the Wanderguard sensor. Two courtyard doors, which were not connected into the Wanderguard system, had a separate alarm system. Code alert testing was completed on all exit doors, three times a week according to interviews with the Maintenance Director and a review of the Code Alert Check Sheet for January, February and March of 2010. The alarm check of the doors were completed daily, since the elopement, and was included as part of the removal of Immediate Jeopardy.

An observation conducted on 03/30/10 at 3:30 PM, revealed Resident #11 was walking, with a purse in hand, and headed for Door #7 on the 500 wing, a roadside exit. The resident pushed on the door and the alarm sounded. The Maintenance Director immediately responded, along with three other staff members to assist the resident away from the door. At 3:40 PM, the resident again attempted to exit the facility

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F 490	Continued From page 32 through the courtyard doors and was intercepted by three staff members. The alarms were observed working properly and staff members responded effectively. Interviews conducted on 03/30-31/10 with staff members included: On the 10:00 PM until 6:00 AM shift; two LPNs, two CNAs and a housekeeper; On the 6:00 AM until 2:00 PM shift; five CNAs, two housekeepers, one RN, two LPNs, two therapists, and one MDS coordinator; On the 2:00 PM until 10:00 PM shift, three CNAs and the Activity Director revealed all staff members expressed an understanding and working knowledge of the Missing Resident and Alarms Policies and all had been inserviced on 03/26-27/10. The remaining non-compliance at F323 at a S/S of a "D" was based on the facility's need to monitor for the ongoing effectiveness of its' revised policies and procedures and to ensure evaluation by the facility's Quality Assurance process.	F 490		

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	185318	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 03/29/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an E.	K 000	K 056 Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19:3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 03/29/10, it was determined the facility failed to ensure the automatic sprinkler system provided complete coverage for all parts of the building as required by NFPA 13, Standards for Sprinkler Systems. Findings to include: Observations of the closets on the 100 Hall and	K 056	Corrective Actions for Targeted Residents On 4/15/10, a contract with a licensed sprinkler company was secured to install sprinkler heads in the cited resident closets on 100 and 200 Halls. Identification of Other Residents with Potential to be Affected Current residents have the potential to be affected. Systematic Changes On 4/15/10, a contract with a licensed sprinkler company was secured to install sprinkler heads in the cited resident closets on 100 and 200 Halls. Work on the project began on 4/15/10 and will continue until completion of the installation. The facility Maintenance Director will conduct monthly checks of the sprinkler system to assure continued compliance. In addition, a contracted licensed sprinkler inspection company will inspect at least quarterly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

4/29/10

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 056	Continued From page 1 200 Hall, on 03/29/10 at 11:40 AM, revealed no evidence of a sprinkler in the closets. An interview with the Maintenance Director, on 03/29/10 at 11:46 AM, revealed the facility was aware of the closets not having sprinklers on the 100 Hall and 200 Hall.	K 056	Monitoring The Maintenance Director will conduct monthly inspections to review for compliance. In addition, a contracted licensed sprinkler company will inspect quarterly to assure compliance. Findings of these inspections will be reported by the Maintenance Director to the Performance Improvement Committee monthly for review and recommendations. The Committee consists of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Assessment Nurse, Maintenance Director, Activities Director, Social Services Director, Housekeeping/ Laundry Supervisor, and Dietary Manager. The Maintenance Director will follow up on any Committee recommendations.	4/15/10
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 03/29/10, it was determined the facility failed to ensure sprinkler heads were free of lint, dust and corrosion as required by NFPA 25 1999 Edition. The findings to include: A tour of the facility conducted 03/29/10 at 10:30 AM, revealed sprinkler heads throughout the 100 Hall and 200 Hall were stained with a brown substance. An interview with the Maintenance Director, on 03/29/10 at 10:35 AM, revealed he was aware of the build-up of corrosion on the sprinkler heads on the older part of the facility and was in the process of getting bids from contractors to replace or repair the sprinkler heads. Reference to:	K 062	K 062 Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Affected Residents A contract was secured on 4/15/10 with a	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF KUTTAWA, LLC	1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055

(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
K 062	Continued From page 2 NFPA 25 1999 Edition 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	licensed sprinkler company to replace sprinkler heads in the cited rooms and halls. Identification of Other Residents with Potential to be Affected Current residents have the potential to be affected. Systematic Changes On 4/15/10, a contract was secured with a licensed sprinkler company to replace the cited sprinkler heads. Work on the project began on 4/15/10 and will continue until completion of the installations The Maintenance Director will conduct monthly checks of the sprinkler system to assure continue compliance. In addition, a contracted licensed sprinkler inspection company will inspect at least quarterly. Monitoring The facility Maintenance Director will conduct monthly inspections to review for compliance. In addition, a contracted licensed sprinkler company will inspect quarterly to assure compliance. Findings of these inspections will be reported by the Maintenance Director monthly to the Performance Improvement Committee for review and recommendations. The Committee consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Assessment Nurse, Maintenance Director, Activities Director, Social Services Director, Housekeeping/ Laundry Supervisor, and Dietary Manager. The Maintenance Director will follow up on any Committee recommendations.	4/15/10