

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

PRINTED: 09/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240	
(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	F 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	9/11/2015
F 241 SS=D	<p>AMENDED</p> <p>A Recertification Survey was conducted on 08/11/15 through 08/14/15 with deficiencies cited at the highest Scope and Severity of a "D".</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for one (1) of twenty-two (22) sampled residents (Resident #10).</p> <p>Observation on 08/12/15, revealed Resident #10 was attempting to use the restroom in his/her room on the bedside commode with two (2) staff present. Resident #10 requested privacy while using the restroom but both staff failed to provide as much privacy as possible by at least one (1) of them leaving the resident's side.</p> <p>The findings include: Record review revealed the facility admitted Resident #10 on 10/31/11 with diagnoses which include Late Effect Hemiplegia, Failure to Thrive</p>	F 241		



What corrective action will be accomplished for those residents found to have been affected?
Resident #10 receives privacy of 1 staff present while using the toilet.

Resident's C.N.A. assignment sheet reflects privacy of one with transfer of two.

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

Francisco M. Arbo

TITLE

Administrator

(X8) DATE

9-11-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>Adult, Dementia with Lewy Bodies, Peripheral Vascular Disease, Constipation, Chronic Pain and Joint Contracture. Review of Resident #10's Quarterly Minimum Data Set (MDS) assessment, dated 06/09/15, revealed the facility assessed Resident #10's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6) which indicates the resident is not interviewable.</p> <p>Observation of Resident #10, on 08/12/15 at 10:40 AM, revealed Resident #10 sitting on the bedside commode attempting to have an elimination episode and was asking for privacy while he/she attempted to use the bedside commode. Certified Nursing Assistant (CNA) #1 was standing directly in front of Resident #10 and CNA #2 was directly behind Resident #10. The Surveyor left the immediate area upon Resident #10's request for privacy, however, both CNAs remained. CNA #1 asked Resident #10 if he/she had any luck yet with using the commode and Resident #10 stated again that she needed some privacy so she could finish.</p> <p>Interview with CNA #1, on 08/12/15 at 10:47 AM, revealed she should have left the immediate area after Resident #10 requested privacy and having only one (1) CNA in his/her immediate area would have been safe and sufficient.</p> <p>Interview with CNA #2, on 08/12/15 at 10:48 AM, revealed a resident's request for privacy should be honored if it was safe to do so and Resident #10 did not need more than one (1) CNA present while he/she was attempting to use the commode. She stated Resident #10 only required one (1) staff to stay and monitor him/her for safety while sitting on the commode and after</p>	F 241	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>Residents requiring 2 staff assist with transfer will have the least number of staff present during toileting while maintaining safety and promoting dignity.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <ol style="list-style-type: none"> 1. Education of all staff regarding Policy on Dignity for the Resident completed on 9/4/2015 by Director of Nursing. 2. C.N.A. Assignment sheet will indicate whether 1 or 2 staff are necessary to assist resident while toileting to provide dignity but maintain safety. Residents requiring 2 staff for safety will provide privacy and be out of view of resident. 		

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F 241	Continued From page 2 Resident #10 was done using the commode she would call for the second CNA to come and assist with toileting care. Interview with the Director of Nursing (DON), on 08/13/15 at 2:43 PM, revealed she expected staff to honor residents wishes for privacy when at all possible as long as it would not of caused a safety issue or concern. She stated she would have expected CNA #1 to have honored Resident #10's wished for privacy while on the commode and that having CNA #2 in close proximity of Resident #10 was sufficient and that would have given Resident #10 greater privacy without CNA #1 being directly in front of Resident #10 while he/she was trying to use the commode. Interview with Administrator, on 08/13/15 at 03:50 PM, revealed she expected staff to provide privacy for the residents at all times when it was safely possible to do so.	F 241	How does the facility plan to monitor its performance to ensure that solutions are sustained? 1. Quality Rounds completed daily by Nursing staff will include an observation for dignity during care. 2. Results of Quality Rounds reported to Unit Manager and D.O.N. for follow up. 3. D.O.N. reports compliance to Quality Assurance Committee (consisting of Administrator, Director of Nursing, Staff Development Coordinator, MDS Coordinator, Environmental Supervisor, Social Services, Dietary Manager, Maintenance Supervisor, Activities Coordinator, Chaplain, Business Office Manager, Case Manager, HR Manager, Medical Director and Medical Records Coordinator) for Recommendations.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14, it was determined the facility failed to provide or arrange services that meet professional standards of quality for one (1) of twenty-two (22) residents (Resident #9). On 08/11/15, LPN #1 was made aware Resident #9 was asking for pain	F 281			

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F 281	<p>Continued From page 3</p> <p>medication; however, the LPN failed to administer the pain medication per the physician's order.</p> <p>The findings include:</p> <p>Review of the KBN AOS #14 Patient Care Orders, last revised 10/2010, revealed licensed staff should administer medication and treatment as prescribed by a physician which includes preparing and giving medications in the prescribed dosage, route and frequency.</p> <p>Review of the Recommendations for the Treatment of Pain Guidelines set by the facility identified that severe pain will receive Dilaudid as ordered by the Physician and Opiate for breakthrough pain as needed. The staff should use distraction and relaxation techniques or other forms of therapy to minimize the pain level. Pain medication shall be given a minimum of thirty (30) minutes prior to any activity where pain can be anticipated, (wound treatment, therapy, Activities of Daily Living (ADL).</p> <p>Record review revealed the facility admitted Resident #9 on 08/07/15 with diagnoses which included Base Femoral Neck Fracture, Acute Pain due to trauma, Pleural Effusion, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Asthma, and history of falls. Further review revealed the Admission Minimum Data Set assessment had not been completed yet; however, interview with the Director of Nursing (DON) on 08/11/15 revealed this resident is interviewable.</p> <p>Review of the Physician's Order, dated 08/07/15, revealed staff should administer Dilaudid 2 milligrams (mg) every three (3) hours as needed</p>	F 281	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Resident #9 had a pain assessment completed by R.N. Unit Manager 8/11/2015 after 9:02 A.M. and pain medication was administered per MD order. Resident #9 care plan was updated to indicate that pain medication be provided as needed prior to therapy.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>Residents scheduled for PRN (as needed) pain medication per x number of hours are assessed for pain on the schedule per MD order.</p>	9/11/2015	

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F 281	<p>Continued From page 4</p> <p>for pain or Acetaminophen 325 mg two (2) tabs every four (4) hours as needed for pain.</p> <p>Observation, on 8/11/15 at 9:02 AM, revealed Resident #9 was laying in bed complaining of severe pain and stated his/her pain scale was an eight (8) out of ten (10). He/she stated she had not received a pain pill since 8:00 PM the previous night. Resident #9 stated they had asked two (2) different staff for a pain pill since before six (6) AM that morning and had not received it. The resident stated he/she was required to perform his/her ADL therapy while in pain but he/she was told he/she could have a pain pill once they were finished with therapy.</p> <p>Interview with the Occupational Therapist Registered (OT/R), on 8/11/15 at 3:27 PM revealed she completed Resident #9's evaluation for ADL assistance on 08/10/15. She stated she treated Resident #9 on 08/11/05 at approximately 6:45 AM and the resident completed a full bath his/herself and dressed his/herself with some assistance. She revealed the therapy lasted approximately sixty-eight to seventy-five (68-75) minutes. She stated the resident complained of pain in the left hip and being up most of the night because the roommate's television was on all night. She revealed when she left the room after multiple transfers during ADL, the resident was still complaining of pain. The OT/R stated she told the nurse that was on the unit (did know the name) Resident #9 was having pain and wanted a pain pill.</p> <p>Review of the August 2015 Medication Administration Record (MAR) revealed there was no documented evidence staff administered the Acetaminophen since admission. Further review</p>	F 281	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <ol style="list-style-type: none"> 1. Physical monitor of Pain Assessment initiated on Post-Operative Residents on PRN pain medication. Physical monitor set per X number of hours per MD order will appear on Nurses medication smartboard for completion. Pain assessment must be completed to remove from smartboard. 2. Education of all Licensed Nursing Staff by Director of Nursing on 9/4/2015 regarding: <ol style="list-style-type: none"> a. Policy on Medication Administration and Standard of Practice for Medication Administration with post test b. New Pain Assessment monitor for Post Op patients on PRN pain medications. 		

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F 281	<p>Continued From page 5</p> <p>revealed staff had only administered Dilaudid 2 mg on 08/10/15 at 8:00 PM. There was no evidence staff provided pain medication per the physician's order prior to therapy or after therapy was completed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/11/15 at 4:25 PM, revealed she was told by the OT/R that Resident #9 was in need of a pain pill however, she was passing other resident medications and told the OT/R she would get to her. She stated she obtained vital signs on Resident #9 around 7:45 AM but did not administer any pain medication at the time she obtained the vital signs.</p> <p>Interview with Unit Manager, on 08/11/15 at 3:45 PM, revealed the resident should be medicated a minimum of thirty (30) minutes prior to any ADL therapy. She stated this was the protocol for her unit and a schedule posted behind the nursing station that indicates which room numbers will have OT and on what days. She revealed the schedule does not indicate a time schedule for the staff to know when to administer the pain medication thirty (30) minutes prior to therapy.</p> <p>Interview with the Director of Nursing (DON), on 08/13/15 at 9:32 AM, revealed there is no working system in place to effectively communicate between nursing and therapy as to the times therapy will be administered so the resident can be administered pain medication per the facility's protocol for pain management. She stated if a resident was in pain they would not be able to perform their ADL or Physical Therapy effectively.</p>	F 281	<p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <ol style="list-style-type: none"> 1. New order review for physical monitor for pain assessment on Post-Operative residents with PRN pain medication completed daily by Unit Managers, Weekend Supervisor or Director of Nursing. 2. Random Audit of pain medication administration for 2 residents per week completed by Unit Manager and results reported to DON. 3. D.O.N. reports to Quality Assurance Committee (consisting of Administrator, Director of Nursing, Staff Development Coordinator, MDS Coordinator, Environmental Supervisor, Social Services, Dietary Manager, Maintenance Supervisor, Activities Coordinator, Chaplain, Business Office Manager, Medical Director, Case Manager, HR Manager, and Medical Records Coordinator) for compliance. 		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			

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F 282	<p>Continued From page 6</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure services provided or arranged by the facility were in accordance with each resident's written plan of care for two (2) of twenty-two (22) sampled residents (Resident #9 and #10). The facility failed to implement the care plans for Resident #10 related to toileting and to provide pain medication to Resident #9.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans, Comprehensive", dated July 2013, revealed an individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, ment and psychological needs is developed for each resident. Care plans are reviewed and revised and the resident's change in conditions dictates.</p> <p>1. Record review revealed the facility admitted Resident #9 on 08/07/15 with diagnoses which included Base Femoral Neck Fracture, Acute Pain due to trauma, Pleural Effusion, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Asthma, and history of falls. Further review revealed the Admission Minimum Data Set (MDS) assessment had not been completed yet; however, interview with the Director of Nursing on</p>	F 282	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Resident #9's care plan was updated to include intervention of Pain Assessment monitor frequency per MD orders for PRN pain medication and communicated to Licensed staff.</p> <p>Resident #10s care plan and Nurse Aide Assignment sheet updated for pattern of voiding and communicated to staff.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents Plan of Care and C.N.A. assignment sheets checked and corrected by Unit Managers and changes updated in red.</p>	9/11/2015	

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F 282	<p>Continued From page 7</p> <p>08/11/15 revealed this resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for alteration in comfort/pain, dated 08/07/15, revealed a goal to control a satisfactory pain level and the resident will exhibit absence of non-verbal pain indicators. Further review revealed interventions for staff to provide medication to control pain as ordered, observe for pain and position to decrease pain.</p> <p>Review of the Physician's Order, dated 08/07/15, revealed staff should administer Dilaudid 2 milligrams (mg) every three (3) hours as needed for pain or Acetaminophen 325 mg two (2) tabs every four (4) hours as needed for pain.</p> <p>Observation, on 8/11/15 at 9:02 AM, revealed Resident #9 was laying in bed complaining of severe pain and stated his/her pain scale was an eight (8) out of ten (10). He/she stated she had not received a pain pill since 8:00 PM the previous night. Resident #9 stated he/she had asked two (2) different staff for a pain pill since before six (6) AM that morning and had not received it. The resident stated he/she had to perform his/her ADL therapy while in pain but he/she was told he/she could have a pain pill once they were finished with therapy.</p> <p>Interview with the Occupational Therapist Registered (OT/R), on 8/11/15 at 3:27 PM revealed she completed Resident #9's evaluation for ADL assistance on 08/10/15. She stated she treated Resident #9 on 08/11/05 at approximately 6:45 AM and the resident completed a full bath his/herself and dressed his/herself with some assistance. She revealed the therapy lasted approximately sixty-eight to seventy-five (68-75)</p>	F 282	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Procedure for C.N.A. Assignment sheet updates to include review and signature q shift by each C.N.A. and sheets turned in to the Charge Nurse daily for review.</p> <p>Education of all nursing staff by Director of Nursing on 9/04/2015 regarding:</p> <ol style="list-style-type: none"> 1 Review of facility Care Plan policy and procedure; 2. Review of requirement to follow care plan interventions; 2. Review of Nurse Aide Assignment sheet procedure and resource for Nurse Aide of current care plan interventions for each resident 	

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F 282	<p>Continued From page 8</p> <p>minutes. She stated the resident complained of pain in the left hip. She revealed when she left the room after multiple transfers during ADL training, the resident was still complaining of pain. The OT/R stated she told the nurse that was on the unit (did know the name) Resident #9 was having pain and wanted a pain pill.</p> <p>Review of the August 2015 Medication Administration Record (MAR) revealed there was no documented evidence staff had provided Acetaminophen or Dilaudid until it was documented the Dilaudid was administered on 08/11/05 at 9:11 AM after surveyor intervention and the medication was effective. The staff failed to follow the resident's care plan related to providing medication for pain.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/11/15 at 4:25 PM, revealed she was told by the OT/R that Resident #9 was in need of a pain pill; however, she was passing other resident medications and told the OT/R she would get to her. She stated she obtained vital signs on Resident #9 around 7:45 AM but did not administer any pain medication per the Comprehensive Care Plan at the time she obtained vital signs.</p> <p>Interview with Unit Manager, on 08/11/15 at 3:45 PM revealed the resident should be medicated a minimum of thirty (30) minutes prior to any ADL therapy. This is a protocol for her unit and is posted at the nursing station what rooms will have Occupational Therapy. She stated she expected that a Comprehensive Care Plan should be developed and followed related to pain management to aid in the resident's therapy and rehabilitation.</p>	F 282	<p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Unit Manager will monitor C.N.A. Assignment sheets daily and Weekend Supervisor will monitor on weekend for compliance. Compliance reported to QA committee (consisting of Administrator, Director of Nursing, Staff Development Coordinator, MDS Coordinator, Environmental Supervisor, Social Services, Dietary Manager, Maintenance Supervisor, Activities Coordinator, Chaplain, Business Office Manager, Case Manager, HR Manager, Medical Director and Medical Records Coordinator) by DON monthly for recommendations.</p> <p>Random audit of 2 residents' medication administration records weekly for completion of the pain assessment and administration as indicated of pain medication by Director of Nursing. Compliance reported monthly to QA committee.</p>	

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F 282	Continued From page 9 Interview with the Director of Nursing (DON), on 08/13/15 at 9:32 AM, revealed the care plan should direct the resident's needs for pain management. 2. Record review revealed the facility admitted Resident #10 on 10/31/11 with diagnoses which included Late Effect Hemiplegia, Failure to Thrive Adult, Dementia with Lewy Bodies, Peripheral Vascular Disease, Constipation, Chronic Pain and Joint Contracture. Review of the Quarterly MDS assessment, dated 06/09/15, revealed the facility assessed Resident #10's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6) which indicated the resident was not interviewable. Further review of this MDS, revealed he/she required extensive assistance of two (2) persons for toileting which indicated Resident #10 was dependent upon staff to assist him/her with toileting needs and review of the Comprehensive Care Plan for Self Care Deficit, dated 12/20/15, revealed an intervention that resident was totally dependent on staff for activities of daily living (ADL) care. Observation of Resident #10, on 08/12/15 at 10:30 AM through 10:35 AM, revealed he/she was yelling out, "Take me to the toilet, I need to go bad." The resident was observed trying to climb over the side of the recliner that he/she was sitting in as he/she was yelling. During this observation Certified Nursing Assistant (CNA) #1 was observed walking past Resident #10 without interacting with him/her or attempting to help him/her and failed to provide toileting per the care plan.	F 282			

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

PRINTED: 09/01/2015
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 10 Interview with CNA #1, on 8/12/15 at 10:35 AM, revealed staff had just taken Resident #10 to the toilet about ten (10) minutes ago and that was why she did not acknowledge Resident #10 yelling out that she needed to use the toilet again. After the interview, CNA #1 asked CNA #2 to help her assist Resident #10 to a wheelchair and take Resident #10 to his/her room and they assisted him/her to the bedside commode. Resident #10 had a continent elimination episode after being transferred to the bedside commode. Interviews conducted on 08/13/15 with Registered Nurse (RN) #1 at 1:10 PM, and the DON at 2:43 PM, revealed they expected staff to acknowledge residents when they were yelling out and requesting to be toileted even if the resident had just been toileted. The DON stated it was not acceptable for staff to disregard a resident requesting to be toileted just because a resident had just recently used the commode and she expected the Comprehensive Care Plan to be followed. Interview with Administrator, on 08/13/15 at 3:50 PM, revealed she expected staff to acknowledge residents and assist the residents when they were yelling out and requesting to be toileted regardless of how recent they had been assisted to the bathroom for toileting needs.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR 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	F 309			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240	
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F 309	<p>Continued From page 11 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure each resident receives and the facility provides 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 for one (1) of twenty-two (22) sampled residents (Resident #9). On 08/11/15, Resident #9 complained of pain and requested pain medication prior to and after therapy; however, licensed staff failed to assess and provide pain medication to alleviate the resident's pain and ensure the resident's therapy would be more successful.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Pain", dated 02/25/15, revealed that the center is to achieve a consistent level of comfort while maintaining as much function as possible for each resident identified with pain, through ongoing assessment, a monitoring system and a specific plan of care.</p> <p>Review of the recommendations for the treatment of pain guidelines set by the facility identified that severe pain will receive Dilaudid as ordered by the Physician and Opiate for breakthrough pain as needed. The staff should use distraction and relaxation techniques or other forms of therapy to</p>	F 309	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Resident #9 had a pain assessment completed by R.N. Unit Manager 8/11/2015 after 9:02 A.M. and pain medication was administered per MD order. Resident #9 care plan was updated to indicate that pain medication be provided as needed prior to therapy.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>Residents scheduled for PRN (as needed) pain medication per x number of hours are assessed for pain on the schedule per MD order.</p>	9/11/2015

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F 309	<p>Continued From page 12</p> <p>minimize the pain level. Pain medication shall be given a minimum of thirty (30) minutes prior to any activity where pain care be anticipated, (wound treatment, therapy, Activities of Daily Living (ADL)).</p> <p>Record review revealed the facility admitted Resident #9 on 08/07/15 with diagnoses which included Base Femoral Neck Fracture, Acute Pain due to trauma, Pleural Effusion, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Asthma, and history of falls.</p> <p>Review of the Initial Pain Assessment, dated 08/07/15, revealed Resident #9 had significant pain needs requiring pain management. Further review revealed the resident was capable of determining his/her level of pain and competent to require medication for pain as needed.</p> <p>Review of the Comprehensive Care Plan for alteration in comfort/pain, dated 08/07/15, revealed a goal to control a satisfactory pain level and the resident will exhibit absence of non-verbal pain indicators. Further review revealed interventions for staff to provide medication to control pain as ordered, observe for pain and position to decrease pain.</p> <p>Review of the Physician's Order, dated 08/07/15, revealed staff should administer Dilaudid 2 milligrams (mg) every three (3) hours as needed for pain or Acetaminophen 325 mg two (2) tabs every four (4) hours as needed for pain.</p> <p>Observation and interview, on 8/11/15 at 9:02 AM, revealed Resident #9 was laying in bed complaining of severe pain and he/she identified his/her pain scale as an eight (8) out of ten (10).</p>	F 309	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Physical monitor of Pain Assessment initiated on Post-Operative Residents on PRN pain medication. Physical monitor set per X number of hours per MD order will appear on Nurses medication smartboard for completion. Pain assessment must be completed to remove from smartboard.</p> <p>Education of all Licensed Nursing Staff by Director of Nursing conducted on 9/4/2015 regarding Policy on Medication Administration and Standard of Practice for Medication Administration.</p> <p>Education of Licensed staff on Physical monitor of pain Assessment initiated on Post Op PRN pain medication orders. All Physical monitors must be completed before they will come off the smartboard.</p>		

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F 309	<p>Continued From page 13</p> <p>The resident stated she had not received a pain pill since eight (8) PM the previous night even though he/she had asked two (2) different staff for a pain pill since before six (6) AM that morning and had not received it. The resident stated he/she was required to perform his/her ADL therapy that morning while in pain but was told by the therapist he/she could have a pain pill once they were finished with therapy.</p> <p>Interview with the Occupational Therapist Registered (OT/R), on 08/11/15 at 3:27 PM revealed she saw Resident #9 on 08/10/15 and completed his/her evaluation for ADL assistance. She stated she treated Resident #9 on 08/11/15 at approximately 6:45 AM and the resident did a full bath his/herself and dressed his/herself with some assistance. The OT/R revealed the therapy lasted approximately sixty-eight to seventy-five (68-75) minutes and the resident complained of left hip pain and of being up most of the night because the roommate's television was on all night. The OT/R stated when she left the room the resident was still complaining of pain so she told the nurse that was on the unit (did know the name) that the resident was having pain and wanted a pain pill.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/11/15 at 4:25 PM, revealed she was told by the OT/R that Resident #9 was in need of a pain pill; however, she was passing other resident medications and told the resident she would get to her/him. LPN #1 stated she obtained vital signs but did not complete a pain assessment and administer pain medication per policy.</p> <p>Interview with Unit Manager, on 08/11/15 at 3:45 PM, revealed a pain assessment should always</p>	F 309	<p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>New order review for physical monitor for pain assessment on Post-Operative residents with PRN pain medication completed daily by Unit Managers, Weekend Supervisor or Director of Nursing.</p> <p>Random Audit of pain medication administration for 2 residents per week completed by Unit Manager and results reported to DON.</p> <p>D.O.N. reports to Quality Assurance Committee (consisting of Administrator, Director of Nursing, Staff Development Coordinator, MDS Coordinator, Environmental Supervisor, Social Services, Dietary Manager, Maintenance Supervisor, Medical Director, Chaplain, Business Office Manager, Case Manager, HR Manager, and Medical Records Coordinator for compliance and recommendations.</p>		

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F 309	Continued From page 14 be performed and the resident should be medicated a minimum of thirty (30) minutes prior to any ADL therapy. She stated this was the protocol for her unit and a schedule was posted behind the nursing station that indicated which room numbers will have OT and on what days. She revealed the schedule does not indicate a time schedule for the staff to know when to administer the pain medication thirty (30) minutes prior to therapy. She stated she expected that a Comprehensive Care Plan should be developed and followed related to pain management to aid in the resident's therapy and rehabilitation. Interview, on 08/13/15 at 9:32 AM with the Director of Nursing (DON), revealed there was no working system in place to effectively communicate between nursing and therapy as to the times therapy will be administered so the resident can be administered pain medication per the facility's protocol for pain management. She stated she expected the residents to have a pain assessment as per the facility policy and pain management was an integral part of their therapy. She revealed of a resident was in pain they would not be able to perform their ADL or Physical Therapy effectively. Additionally, she stated a care plan should direct the resident's needs for pain management.	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	What corrective action will be accomplished for those residents found to have been affected? Resident #10 is toileted each time resident requests and according to established voiding pattern.	9/11/2015	

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F 315	<p>Continued From page 15</p> <p>who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents who are incontinent receive appropriate services to restore as much normal bladder function as possible for one (1) of twenty-two (22) sampled residents (Resident #10). Observation on 08/12/15 revealed Resident #10 was yelling out to use the restroom and the Certified Nurse Aide (CNA) failed to assist the resident for toileting.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #10 on 10/31/11 with diagnoses which included Late Effect Hemiplegia, Failure to Thrive Adult, Dementia with Lewy Bodies, Peripheral Vascular Disease, Constipation, Chronic Pain and Joint Contracture. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 06/09/15, revealed the facility assessed Resident #10's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6) which indicated the resident was not interviewable. Further review of this MDS, revealed he/she required extensive assistance of two (2) persons for toileting which indicated Resident #10 was dependent upon staff to assist him/her with toileting needs.</p> <p>Review of the Comprehensive Care Plan for Self</p>	F 315	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents requesting to be toileted will be acknowledged and taken to the toilet as soon as possible.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Education provided by Director of Nursing to all Staff on 9/4/2015 regarding:</p> <ul style="list-style-type: none"> . Requirement to acknowledge residents who are asking for assistance and provide assistance if qualified or let resident know that they will get someone. . Licensed nurses and CNAs are required to assist residents as requested. If this is outside their usual pattern then resident should be assessed for change of condition by appropriate staff member and MD notified if appropriate. 		

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F 315	<p>Continued From page 16</p> <p>Care Deficit, dated 12/20/15, revealed an intervention that resident was totally dependent on staff for activities of daily living (ADL) care.</p> <p>Observation of Resident #10, on 08/12/15 at 10:30 AM through 10:35 AM, revealed he/she was yelling out, "Take me to the toilet, I need to go bad." The resident was observed trying to climb over the side of the recliner that he/she was sitting in as he/she was yelling. During this observation Certified Nursing Assistant (CNA) #1 was observed walking past Resident #10 without interacting with him/her or attempting to help him/her. After five (5) minutes of observing Resident #10 yelling out and attempting to climb out of the recliner, the surveyor interviewed CNA #1. Interview with CNA #1, on 8/12/15 at 10:35 AM, revealed staff had just taken Resident #10 to the toilet about ten (10) minutes ago and that was why she did not acknowledge Resident #10 yelling out that she needed to use the toilet again. Further observation after CNA #1 was interviewed by the surveyor revealed CNA #1 asked CNA #2 to help her assist Resident #10 to a wheelchair and take Resident #10 to his/her room and they assisted him/her to the bedside commode. Resident #10 had a continent elimination episode after being transferred to the bedside commode.</p> <p>Interview with Registered Nurse (RN) #1, on 08/13/15 at 1:10 PM, revealed she expected staff to attend to residents when they were yelling out and attempting to climb out of a chair unassisted. She further stated staff were to check on a resident who stated they needed to use the toilet.</p> <p>Interview with Director of Nursing (DON), on 08/13/15 at 2:43 PM, revealed she expected staff to acknowledge residents when they were yelling</p>	F 315	<p>Care plan interventions and Nurse Aide Assignment sheet is adjusted by Unit Manager to reflect resident needs as indicated.</p> <p>Documentation by CNAs in ADL record of toileting frequency completed daily.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Quarterly check offs with CNAs by Staff Development Coordinator or Unit Managers for competency in following care plan.</p> <p>Random audit of 2 residents per week by Unit Manager for compliance with care plan interventions and reported to the Director of Nursing.</p>		

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F 315	Continued From page 17 out and requesting to be toileted even if the resident had just been toileted. She further stated it was not acceptable for staff to disregard a resident requesting to be toileted just because a resident had just recently used the commode. Interview with Administrator, on 08/13/15 at 3:50 PM, revealed she expected staff to acknowledge residents and assist the residents when they were yelling out and requesting to be toileted regardless of how recent they had been assisted to the bathroom for toileting needs.	F 315	Director of Nursing reports compliance to the QA committee (consisting of Administrator, Director of Nursing, Staff Development Coordinator, MDS Coordinator, Environmental Supervisor, Social Services, Dietary Manager, Maintenance Supervisor, Activities Coordinator, Chaplain, Business Office Manager, Case Manager, HR Manager, Medical Director and Medical Records Coordinator) for recommendations.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185147	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 09/14/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240	
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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 09/14/15, as alleged.	{K 000}		

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

TITLE

(X8) DATE

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185147	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 9/14/2015
Name of Facility CHRISTIAN HEALTH CENTER		Street Address, City, State, Zip Code 200 STERLING DR. HOPKINSVILLE, KY 42240

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0018	Correction Completed 09/11/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0025	Correction Completed 09/04/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0046	Correction Completed 09/11/2015
ID Prefix _____ Reg. # NFPA 101 LSC K0072	Correction Completed 09/11/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 09/14/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <i>IOH</i>	Date: <i>09/15/15</i>	Signature of Surveyor: <i>Deborah A. Henderson Netz, DC</i>	Date: <i>09/15/15</i>
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
8/11/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1977.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1977, upgraded in 1998 with 102 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system installed in 1977.</p> <p>GENERATOR: Type II generator installed in 1977. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 08/11/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred fourteen (114) beds with a census of one-hundred two (102) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> 	

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

TITLE

(X6) DATE

Francis M. Marko Administrator 9/11/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Fire).	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, six (6) residents, staff and</p>	K 018	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Resident room #315 door hinge was adjusted and door was able to latch.</p> <p>Resident room #9 door hinge was adjusted and door was able to latch.</p> <p>Resident room #10 corridor door was released from the bathroom door Knob and is able to latch.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All resident room doors have been inspected and are able to latch.</p>	9/11/2015

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K 018	<p>Continued From page 2</p> <p>visitors. The facility has the capacity for one-hundred fourteen (114) beds and at the time of the survey, the census was one-hundred two (102).</p> <p>The findings include:</p> <p>1. Observation, on 08/11/15 at 3:35 PM, with the Maintenance Director revealed the corridor door to resident room #315 would not latch when tested.</p> <p>Interview, on 08/11/15 at 3:36 PM, with the Maintenance Director revealed he was unaware the door would not latch.</p> <p>2. Observation, on 08/11/15 at 3:51 PM, with the Maintenance Director revealed the corridor door to resident room #9 would not latch when tested. Further observation revealed the corridor door to room #10 was obstructed from closing due to the bathroom door knob being used to hold the door open.</p> <p>Interview, on 08/11/15 at 3:52 PM, with the Maintenance Director revealed he was unaware the door would not latch and staff had been instructed not to use the bathroom door to hold open the door to the corridor.</p> <p>The census of one-hundred two (102) was verified by the Administrator on 08/11/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/11/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1*</p>	K 018	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Resident room door latches for 100, 200, 300, and TTH will be added to the monthly room audits and checked to ensure that they all latch.</p> <p>Resident room doors will have a stainless steel door knob guard installed to prevent the door from being held open by the bathroom door knob.</p> <p>All staff received education that the corridor doors of the resident rooms cannot be held open with the bathroom door knobs and that door knob guards are installed on the corridor doors to prevent securing the corridor door with the bathroom door by the Administrator on 9/4/2015.</p>	

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K 018	<p>Continued From page 3</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.</p> <p>Reference: CMS: S&C-07-18</p>	K 018	<p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Maintenance technician will report to QA committee (consisting of Administrator, Director of Nursing, Staff Development Coordinator, MDS Coordinator, Environmental Supervisor, Social Services, Dietary Manager, Maintenance Supervisor, Chaplain, Medical Director, Activities Coordinator, Business Office Manager, Case Manager, HR Manager, and Medical Records Coordinator) monthly the results of the monthly monitor for compliance and recommendations.</p>	

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K 025 K 025 SS=E	Continued From page 4 NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred fourteen (114) beds and at the time of the survey, the census was one-hundred two (102). The findings include: 1. Observation, on 08/11/15 at 1:17 PM, with the Maintenance Director revealed a penetration around a duct pipe located above the ceiling of the Activities Office. Interview, on 08/11/15 at 1:18 PM, with the Maintenance Director revealed he was not aware	K 025 K 025	What corrective action will be accomplished for those residents found to have been affected? Smoke barrier wall above Activities office had sheet rock and fire caulk applied to complete the other side of the wall under the air duct. Smoke Barrier penetrations near the Therapy gym were fire caulked to seal around the penetrations. How the facility will identify other residents having the potential to be affected by the same deficient practice? All smoke barrier walls were inspected from the attic and from below by the Maintenance Supervisor to ensure all penetrations were sealed on 8/31/2015. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Smoke barrier walls will be inspected after any installation or maintenance done in the attic. The inspection will be completed by maintenance technician and repair made as needed.	9/04/2015	

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K 025	<p>Continued From page 5 of the penetration.</p> <p>2. Observation, on 08/11/15 at 1:20 PM, with the Maintenance Director revealed penetrations around pipes located above the ceiling in the Hallway to Therapy Gym.</p> <p>Interview, on 08/11/15 at 1:21 PM, with the Maintenance Director revealed he was not aware of the penetrations.</p> <p>The census of one-hundred two (102) was verified by the Administrator on 08/11/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/11/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition) 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air</p>	K 025	<p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Smoke barrier walls will be inspected with monthly building inspection to monitor barrier compliance with repair done as indicated. Compliance will be reported to QA committee m(consisting of Administrator, Director of Nursing, Staff Development Coordinator, MDS Coordinator, Environmental Supervisor, Social Services, Dietary Manager, Maintenance Supervisor, Chaplain, Medical Director, Activities Coordinator, Business Office Manager, Case Manager, HR Manager, and Medical Records Coordinator) monthly for follow up and recommendations</p>	

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K 025	Continued From page 6 ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025			

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K 046 K 046 SS=F	Continued From page 7 NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred fourteen (114) beds and the census was one-hundred two (102) on the day of the survey. The findings include: Record review, on 08/11/15 at 2:25 PM, with the Maintenance Director revealed the facility failed to document the monthly thirty (30) second test and the annual ninety (90) minute test for battery powered emergency lighting. Interview, on 08/11/15 at 2:26 PM, with the Maintenance Director revealed he was not aware that documentation was to be provided for the thirty (30) second monthly and ninety (90) minute test for battery powered emergency lighting. The census of one-hundred two (102) was verified by the Administrator on 08/11/15. The survey findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/11/15.	K 046 K 046	What corrective action will be accomplished for those residents found to have been affected? Battery powered emergency lighting was checked for 30 seconds and 90 minutes and documented as in working order by Maintenance Technician on 8/31/2015. How the facility will identify other residents having the potential to be affected by the same deficient practice? The battery operated emergency lighting will be tested 30 seconds monthly and annually for 90 minutes.	9/11/2015

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K 046	Continued From page 8 Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual	K 046	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Emergency Generator & Battery Light Inspection form has been updated to include the battery operated emergency light test for 30 seconds monthly and 90 minutes yearly. The date for the annual 90 minute test has been added to the form and test and results to be documented. Maintenance Technician in serviced on new form and testing requirement by Maintenance Director 8/31/2015. How does the facility plan to monitor its performance to ensure that solutions are sustained? The Emergency Generator & Battery Light Inspection form will be turned in to the Maintenance Director monthly and reported to Quality Assurance Committee monthly for compliance.	

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K 046	Continued From page 9	K 046		
K 072 SS=E	<p>Inspection is performed at 30-day intervals.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred fourteen (114) beds and at the time of the survey, the census was one-hundred two (102).</p> <p>The findings include:</p> <p>1. Observation, on 08/11/15 at 2:55 PM, with the Maintenance Director revealed a lift, blood pressure machine and two (2) bed tables were being stored in the egress path of the 100 Hall.</p> <p>Interview, on 08/11/15 at 2:56 PM, with the Maintenance Director revealed the items were not routinely stored in this location.</p> <p>2. Observation, on 08/11/15 at 3:27 PM, with the Maintenance Director revealed a lift, two (2)</p>	K 072	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <ol style="list-style-type: none"> 1. Lift, blood pressure machine and over bed tables were removed from egress path on 100 wing. 2. The lift, 2 wheel chairs and linen cart were removed from the egress path on 200 wing. 3. The lift was removed from the egress path on 300 wing. <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All lifts have been removed from storage at the end of the halls on all wings. Resident wheel chairs are moved to each resident's room. Linen carts stored next to nurse's station.</p>	9/11/2015

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K 072	<p>Continued From page 10</p> <p>wheelchairs and a linen cart were being stored in the egress path of the 200 Hall.</p> <p>Interview, on 08/11/15 at 3:28 PM, with the Maintenance Director revealed the items were not routinely stored in this location.</p> <p>3. Observation, on 08/11/15 at 3:37 PM, with the Maintenance Director revealed a lift was being stored in the egress path of the 300 Hall.</p> <p>Interview, on 08/11/15 at 3:38 PM, with the Maintenance Director revealed the items were not routinely stored in this location.</p> <p>The census of one-hundred two (102) was verified by the Administrator on 08/11/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/11/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>Reference: NFPA 101 (200 Edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.</p>	K 072	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>All staff were educated 9/04/2015 by Administrator regarding changes in:</p> <ol style="list-style-type: none"> 1. storage of lifts into the weight room, 2. overbed tables and wheel chairs into each resident's room; 3. storage of blood pressure monitors into the nurse's station; and 4. requirement that egress path be clear of equipment at all times. <p>Maintenance Tech to check egress path Daily and remove anything in that path. This will be recorded on daily Maintenance Check list. Any items in egress path will be removed.</p>	

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

PRINTED: 08/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185147	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2015
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240		
(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 144	<p>Continued From page 12</p> <p>review revealed the facility did not have documentation for monthly transfer times or that the annual preventative maintenance had been performed.</p> <p>Interview, on 08/11/15 at 2:22 PM, with the Maintenance Director revealed he was not aware of the requirements for generator testing.</p> <p>The census of one-hundred two (102) was verified by the Administrator on 08/11/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/11/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1*</p> <p>The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-4.2*</p> <p>Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility</p>	K 144	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>The emergency generator will be tested monthly for a minimum of 30 minutes and the exhaust temperature, and transfer times will be documented.</p> <p>If the monthly testing does not meet the 30 % of EPS nameplate rating or meet the minimum exhaust temperature as recommended by the manufacturer, then an annual load bank test will be performed with the annual preventative maintenance by contracted company.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The emergency generator test will be completed monthly with the exhaust temperature and transfer time added to the documentation.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240		
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K 144	Continued From page 13 operations. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144	Private Generator Contractor to train Maintenance Director and Maintenance Technician on 9/14 on how to measure exhaust temperature and minimum requirement for the existing generator. How does the facility plan to monitor its performance to ensure that solutions are sustained? The Emergency Generator Test form will be turned in monthly to the Maintenance Director and reported To Quality Assurance committee Monthly for compliance and Recommendations.		

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207, or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 185147	Provider/Supplier Name CHRISTIAN HEALTH CENTER
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Type of Survey (select all that apply)

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- A Complaint Investigation
- B Dumping Investigation
- C Federal Monitoring
- D Follow-up Visit
- M Other
- E Initial Certification
- F Inspection of Care
- G Validation
- H Life Safety Code
- I Recertification
- J Sanctions/Hearing
- K State License
- L CHOW

Extent of Survey (select all that apply)

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- A Routine/Standard Survey (all providers/suppliers)
- B Extended Survey (HHA or Long Term Care Facility)
- C Partial Extended Survey (HHA)
- D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30055	08/11/2015	08/11/2015	0.50	0.00	4.00	0.00	3.50	3.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....	1.50	Total RO Supervisory Review Hours.....	0.00
Total SA Clerical/Data Entry Hours.....	2.00	Total RO Clerical/Data Entry Hours.....	0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Division of Health Care
P.O. Box 2200 / 2400 Russellville Road
Hopkinsville, Kentucky 42240
Phone: (270) 889-6052
Fax: (270) 889-6089
<http://chfs.ky.ov/os/oig>

Audrey Tayse Haynes
Secretary

Maryellen B. Mynear
Inspector General

September 24, 2015

via EMAIL: Frances M. Marko (Fran.Marko@ccc1884.org)

Ms. Frances M. Marko, Administrator
Christian Health Center Hopkinsville - S/NF DP
200 Sterling Drive
Hopkinsville, KY 42240

Dear Ms. Marko:

Thank you for submitting your proposed plan of correction regarding the deficiencies noted during the survey completed on August 14, 2015.

We are accepting your allegation of compliance and presume that substantial compliance was achieved by September 14, 2015, as alleged in your plan of correction. Therefore, we are not recommending the remedies referred to in the initial notice dated August 28, 2015, to the Centers for Medicare and Medicaid Services Regional Office at this time. Based on implementation of your plan of correction, we will recommend that your nursing facility be relicensed and recertified for continued participation in the Title XVIII/XIX programs contingent upon approval from the appropriate agencies.

Your cooperation is appreciated. If you should have questions regarding this information, please contact our office.

Sincerely,

A handwritten signature in blue ink that reads "Kathy Perry".

Kathy Perry, RN, BSN, MA
Regional Program Manager

KDP/BWA:lef



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Division of Health Care
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Audrey Tayse Haynes
Secretary

Maryellen B. Mynear
Inspector General

September 1, 2015

via EMAIL: Frances M. Marko (Fran.Marko@ccc1884.org)

Ms. Frances M. Marko, Administrator
Christian Health Center Hopkinsville - S/NF DP
200 Sterling Drive
Hopkinsville, KY 42240

AMENDED CMS2567/SOD

Dear Ms. Marko:

On August 14, 2015, a standard Health and Life Safety Code recertification survey was completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This visit found that your facility was not in substantial compliance with the participation requirements. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567, whereby corrections are required **(F)**.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (POC)

A POC for the deficiencies must be submitted **no later than ten (10) days from receipt of this letter**. Failure to submit an acceptable POC may result in a recommendation that remedies be imposed immediately upon notification requirements being met. Your POC, as fully implemented, will serve as your allegation of compliance.

Your POC must:

- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date,' include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed Forms CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

Recommended Remedies

As a result of our finding that your facility was not in compliance with participation requirements, the State Agency reserves the right to recommend discretionary remedies to the Centers for Medicare and Medicaid Services (CMS) Regional Office if substantial compliance has not been achieved by **September 28, 2015**.

If you do not achieve substantial compliance within three (3) months from the last day of the survey identifying noncompliance, the CMS Regional Office must deny payments for new admissions.

Your provider agreement must be terminated if substantial compliance is not achieved within six (6) months from the last day of the survey identifying noncompliance.

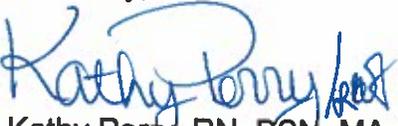
Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare and Medicaid Services determine that termination or any other sanction is warranted, it will provide you with a separate formal notification of that determination.

Informal Dispute Resolution

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes Substandard Quality of Care or Immediate Jeopardy. You are required to send your request in writing to **IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621**. Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute, and provide a detailed basis for the dispute. Documentation in support of the dispute shall be attached to the request. The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies**. A request for informal dispute resolution shall not delay an enforcement action.

If you should have questions regarding this information, please contact our office.

Sincerely,



Kathy Perry, RN, BSN, MA
Regional Program Manager

KDP/BWA:lef

Enclosure



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Division of Health Care
P.O. Box 2200 / 2400 Russellville Road
Hopkinsville, Kentucky 42240
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<http://chfs.ky.ov/os/oig>

Audrey Tayse Haynes
Secretary

Maryellen B. Mynear
Inspector General

August 28, 2015

via EMAIL: Frances M. Marko (Fran.Marko@ccc1884.org)

Ms. Frances M. Marko, Administrator
Christian Health Center Hopkinsville - S/NF DP
200 Sterling Drive
Hopkinsville, KY 42240

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If you should have questions regarding this information, please contact our office.

Sincerely,

A handwritten signature in blue ink that reads "Kathy Perry". The signature is written in a cursive style with a large initial "K".

Kathy Perry, RN, BSN, MA
Regional Program Manager

KDP/BWA:lef

Enclosure

No class for multiple years

DEPARTMENT FOR MEDICAID SERVICES
PROGRAM VISIT REPORT
NURSING FACILITY

OIG
SURVEY DATE:

08/11/15

Facility Name: Christian Health Center

Facility Address: 200 Sterling Dr, Hopkinsville, Ky

Nurse Aide Training Provider Number: 0302009

Program Coordinator: Sharilyn Alvest, RN DAN
(Can be Director of Nurses)

Program Instructor: Vecki Mc Knight
(Cannot be Director of Nurses)

MOI: Yes () No () 2 years as R.N.: Yes () No () 1 year long term experience: Yes () No ()

Yes	No	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Course Curriculum - Adapted Mosby's Textbook for LTC Assistants as of July 1, 1997.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Observed Classroom (i.e. necessary equipment and supplies available). <u>6th Edition Book</u>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Observed class in session.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Observed clinicals performed. <u>Mandatory 03/01/11.</u>

1. Is the learning environment conducive for adult students: (i.e. well-lighted, well-ventilated, quiet)?

2. What evidence exists that the class is being conducted within submitted plan?

3. Is there sufficient number of faculty to meet ratios for classroom and clinical (maximum is 1:15)?

4. Is there documentation of staff development offered to nurse aides (12 hours/year): Yes () No ()

- | Yes | No | |
|-------------------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 5. Are performance records available to nurse aide and employer? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 6. Are performance records maintained for a minimum of five (5) years? |
| <input type="checkbox"/> | <u>N/A</u> | 7. Pass/Fail for last two (2) classes: Date: _____ # Pass: _____ # Fail: _____
Date: _____ # Pass: _____ # Fail: _____ |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 8. Does facility notify Medicaid of <i>all</i> program changes within thirty (30) days?
(i.e. new administrator, classroom, coordinator, instructor) |

Signature of Reviewer: William D. Derosa

Date: 08/11/15