

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

PRINTED: 07/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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F 000 INITIAL COMMENTS

A Standard Survey for Recertification was initiated on 07/08/13 and concluded on 07/10/13. Deficiencies were cited with the highest Scope and Severity of an "F".

F 280: 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of facility policies, it was determined the facility failed to ensure the Comprehensive Plans of Care were revised for two (2) of twenty-two (22)

F 000 The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/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 of federal and state law.

F 280

RECEIVED
AUG - 2 2013
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ronald A. [Signature]</i>	TITLE Senior Executive Director	(X6) DATE 8/2/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280 Continued From page 1 sampled residents.

Resident #13 was observed by staff to be punching the buttons of the tube feeding pump and also noted to be pulling on the gastric tubing of Resident #17; however, there was no documented evidence these residents Comprehensive Plans of Care were revised related to these behaviors with interventions to prevent reoccurrence.

The findings include:

Review of the facility's "Care Plans" Policy, revised 05/12, revealed the Unit Managers review orders and clinical issues daily and update the care plan as indicated with new or discontinued treatments and changes of conditions.

1. Review of Resident #13's clinical record revealed diagnoses which included Dementia with Psychosis, and Cerebral Vascular Disease (CVA) with Hemiplegia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/27/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of 03, indicating cognitive impairment. Further review revealed the facility assessed the resident as requiring the assistance of one (1) staff for transfers and ambulating.

Review of Resident #13's Comprehensive Plan of Care, dated 04/02/13 revealed the resident had altered thought processes and mild to moderate confusion. An update on 05/19/13 revealed the resident was having episodes of hallucinations.

Further review revealed a Care Plan update

F 280

1) The facility has interim or comprehensive care plans for all residents within the facility. Each resident has multiple medically-related problems each having multiple care approaches. The facility has a system in place for updating care plans with new approaches, changes in resident's conditions and revised interventions.

Both Resident #13 and #17 plans of care were reviewed by the unit manager to ensure current treatments, changes and approaches are incorporated into the care plan.

2) A 100% sample of all resident's care plans will be completed by licensed nurses to ensure the care plan accurately reflects the resident's current condition and treatment.

3) The unit managers, MDS RN Coordinators and Assistant Director of Nursing will be re-educated on the roles, responsibilities and system of updating care plans by the Director of Nursing. An indicator will be incorporated into the existing QA program related to care plan accuracy and current reflection of the resident's condition and treatments. This will be a retrospective review collected monthly for 12 months utilizing a 10% sample of care plans.

4) The Director of Nursing will provide a report to the QA committee monthly for 12 months.

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07/03/13 which stated the resident had a problem of disruptive behavior, could be agitated with others, and was resistive to care. The goat stated the resident would not cause injury to self or others. The interventions included; observe for changes in behavior, be aware of the tendency to get up at night and rummage and ensure safety of resident and others, observe for problems related to a recent new roommate and address problems as they arise.

Observation of Resident #13, on 07/09/13 at 9:45 AM, revealed the resident was standing and attempting to make the bed. On 07/09/13 at 3:55 PM, observation revealed the resident was standing up across the room from the bed going through the top dresser drawer.

Review of a Nurse's Note, dated 07/01/13 at 10:30 PM, revealed the nurse was doing rounds when noting Resident #13 was pushing buttons to the tube feeding pump machine of the resident's roommate (Resident #17). Per the Note, the nurse explained to the resident she/he was not to touch the machine and the night shift supervisor was notified.

Another Nurse's Note, dated 07/02/13 at 10:10 PM, revealed Resident #13 was having increased agitation and yelling out for her/his roommate (Resident #17) to get out of the room. According to the Note, the Nurse walked in the room and noted Resident #13 was pushing buttons on Resident #17's tube feeding machine. Resident #13 stated, this man is trying to get me. Per the Note, the nurse explained that the pole was a feeding tube pump, not a man and she/he would be okay.

F 280 Compliance Date: August 24, 2013

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Further review of Resident #13's Plan of Care revealed there was no reference to these behaviors of pushing buttons on the tube feeding machine for Resident #17; and no documented interventions to address these behaviors.

2. Review of Resident #17's clinical record revealed the resident was admitted to the facility on 06/05/13 with diagnoses of Intestinal Obstruction, Status/Post Peg Placement (percutaneous endoscopic gastrostomy), and Alzheimer's Dementia. Review of the Admission Minimum Data Set (MDS) Assessment, dated 06/12/13 revealed the facility had assessed the resident as having a Brief Interview of Mental Status (BIMS) of a five (5) indicating cognitive impairment. Further review revealed the facility assessed the resident as requiring the extensive assist of two (2) staff for transfers, and the extensive assist of one (1) staff for ambulation. Further review revealed the resident was moved to the locked unit on 07/10/13.

Review of Resident #17's Plan of Care, revealed there was no reference to the roommate (Resident #13) pushing the buttons of the tube feeding machine and no interventions in an attempt to prevent reoccurrence.

Review of the July 2013 Physician's Orders for Resident #17 revealed orders for Diabatasource AC from 7:00 PM until 9:00 AM at 75 milliliters per hour.

Interview, on 07/10/13 at 12:17 PM, with Certified Nursing Assistant (CNA) #8 revealed she was frequently assigned to Resident #13 and although

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she had not seen her/him around Resident #17's tube feeding pump recently; she had seen Resident #13 fiddling with Resident #17's tube feeding tubing in the past.

Interview, on 07/10/13 at 12:39 PM, with Licensed Practical Nurse (LPN) #2 revealed Resident #17 was only recently moved to the locked unit on 07/02/13 and staff had concerns about how the room arrangement would work because Resident #13 had the room to herself/himself for a long time. She stated she worked a lot of evening shifts and had never witnessed Resident #13 to bother Resident #17's tube feeding pump and stated Resident #17 only received tube feedings from 7:00 PM until 9:00 AM. She further stated she was aware there had been concerns related to Resident #13 bothering Resident #17's tube feeding pump and staff was trying to figure out what would work best because a change in rooms may not work since most of the residents on the locked unit were mobile. Further interview revealed staff had tried placing a pillowcase over Resident #17's tube feeding pole at first; however, that did not work because Resident #13 thought it was a person. She stated the tube feeding rate on the machine could not be changed unless the buttons were held for a period of time and there was a sequence of buttons to push to change the rate. Continued interview revealed there was no special monitoring of Resident #13 or Resident #17 initiated after the incidents where Resident #13 was noted to push the tube feeding buttons.

Interview, on 07/10/13 at 3:35 PM with CNA #9, revealed she checked on all the residents every fifteen (15) to twenty (20) minutes; however, she

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F 280	<p>Continued From page 5</p> <p>was unaware of any special monitoring for Resident #13 and #17.</p> <p>Interview, on 07/10/13 at 4:00 PM, with Registered Nurse (RN) #1 revealed she worked the evening shift and had witnessed and reported to the night shift supervisor that Resident #13 was touching Resident #17's tube feeding pump. She further stated the care plans were not revised for any special monitoring or interventions related to this for Resident #13 and #17; however, she was up and down the hall all the time. Further interview revealed the CNA's were to also monitor and let the nurses know if there was a concern. RN #1 stated Resident #17 was also able to let staff know if anyone bothers her/him.</p> <p>Interview, on 07/10/13 at 4:09 PM, with CNA #2 revealed all the residents were monitored hourly after they were in bed. She stated Resident #17 has alerted staff when Resident #13 rummaged through her/his dresser drawers.</p> <p>Interview, on 07/10/13 at 4:41 PM, with the Unit Manager on the locked unit revealed she was aware that Resident #13 had touched Resident #17's tube feeding pump although she was unaware of Resident #13 touching the tube feeding tubing. She stated staff had tried manipulating the pole to hide behind the curtain and a pillowcase was applied over the tube feeding to camouflage the pump. Continued interview revealed the care plans for Resident #13 and #17 should have been addressed with revisions after the occurrences on 07/01/13 and 07/02/13. She stated she or any nurse could have revised the care plans including the</p>	F 280	

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Assistant director of Nursing (ADON) who was serving as the interim Director of Nursing (DON) until last week when the new DON started. Further interview revealed the care plans should have been revised to show the behaviors and the interventions which were placed such as the pillow case on the pole and manipulation to hide the pole. She stated she had not thought about more frequent monitoring of the residents and staff felt this was just something that occurred during the adjustment period of receiving a new roommate.

Interview, on 07/10/13 at 5:40 PM with the ADON revealed the nurses and the Nurse Manager were checking on Resident #13 and #17 more frequently and at least hourly, and they had tried pulling a pillow case over the tube feeding pump which was unsuccessful. She stated the issue was discussed in the stand up meeting and they felt this was an adjustment period for Resident #13 and she/he needed time to get used to a roommate. Further interview revealed she was unaware Resident #13 had ever pulled on the tube feeding tubing and stated the administrative staff should have had more discussion with the night nurses to understand what they were seeing. Continued interview revealed the care plans for both residents should have been revised to include the interventions they had tried such as at least hourly checks and pulling the pillow case over the pole. She further indicated since the concern was noted with this survey, they had rearranged the beds in the room and asked Resident #17 if she/he wanted a room change which she/he declined.

Interview, on 07/10/13 at 6:20 PM, with the DON

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revealed she had only been in the position for a week. She stated she would expect frequent monitoring of the residents and she would also expect documentation in the care plans of behaviors and interventions as needed for both residents. Continued interview revealed there should have been education/inservicing for the staff related to what was expected to prevent reoccurrence.

F 280

F 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

F 323

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 observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure the resident remains as free of accident hazards as is possible and each resident receives adequate supervision to prevent accidents for two (2) of twenty-two (22) sampled residents (Resident #13, and #17).

Resident #13 was observed to have a pocket knife in possession which was retrieved by staff and given to the social worker. However, there was no documented evidence of an investigation and no documented evidence administrative staff

1) This facility maintains an environment that minimizes accidents and the potential for accidents. Resident #17's room was audited by staff at the time of the initial report and on 7/9/13 to ensure no accident hazards were present. Resident #13's room was reconfigured on 7/9/13 to eliminate the potential for Resident #17 to touch Resident #13's pump. Resident #13 was moved to another resident room on July 16, 2013.

2) An audit of all resident rooms will be completed by unit managers or designees

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F 323	<p>Continued From page 8</p> <p>were notified in order to form a plan of action to prevent reoccurrence.</p> <p>Also, Resident #13 was observed by staff to be punching the buttons of the tube feeding pump for Resident #17 and also noted to be pulling on the gastric tubing; however, there was no documented evidence of interventions to prevent reoccurrence.</p> <p>The findings include:</p> <p>Review of the facility's, "Accidents and Incidents Policy", undated, revealed all incidents occurring on the premises must be investigated. An incident is any occurrence which was not consistent with the routine operation of the facility or the routine care of a particular resident. The purpose of this procedure was to provide a written record to document facts of deviations from the standard of care and corrective measure to prevent recurrence. Regardless of how minor an incident may be, it must be reported to the department supervisor and an Accident/Incident Report Form was to be initiated on the shift in which the accident/incident occurred. An employee witnessing an incident involving a resident must report such occurrence to his/her immediate supervisor as soon as practical. The Accident/Incident Report was forwarded to the Director of Nursing (DON) or Administrator within twenty-four (24) hours of completion. Pertinent information was charted in the medical record, using the incident report from a guide.</p> <p>1. Review of Resident #13's medical record revealed diagnoses which included Dementia with Psychosis, and Cerebral Vascular Disease (CVA)</p>	F 323	<p>to determine if there are any accident hazards. Any accident hazards noted on these audits will be corrected (EXHIBIT 1).</p> <p>2) All staff will be re-educated on the facility's Accident and Incident policy by the Staff Development Coordinator and/or Department Director. Additionally, the facility will mail information to each resident's responsible party to re-educate them on the avoidance of bringing the resident any item(s) that could be considered an accident hazard. The facility has designed an indicator tool (EXHIBIT 2) to assess resident rooms for accident hazards. This indicator tool will be incorporated in to the</p>	

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with Hemiplegia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 06/27/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of 03, indicating cognitive impairment. Further review revealed the facility assessed the resident as requiring the assistance of one (1) staff for transfers and ambulating.

Review of Resident #13's Comprehensive Plan of Care dated 04/02/13 revealed the resident had altered thought processes and mild to moderate confusion. An update on 05/19/13 revealed the resident was having episodes of hallucinations.

Observation of Resident #13, on 07/09/13 at 9:45 AM revealed the resident was standing by her/his bed attempting to make the bed. On 07/09/13 at 3:55 PM revealed the resident was standing up across the room from the bed going through the top dresser drawer.

Review of the Nurse's Notes for Resident #13 dated 05/19/13, no time noted, revealed the resident was in her/his room bending over cutting tile with a pocket knife. The Note was written by Licensed Practical Nurse (LPN) #4

Interview was attempted, on 07/10/13 at 2:00 PM by phone with LPN #4; however, the nurse was unable to be reached and did not return the call.

Interview, on 07/10/13 at 12:32 PM with Certified Nursing Assistant (CNA) #5, revealed she was assigned to Resident #13 on the day the knife was found; however, she was not the person who found the knife. She stated the nurse found the knife and it was a small pocket knife with two (2)

F 323: facility's existing QA program and will be a concurrent review collected by observation by the unit managers monthly for 12 months.

4) The DON will provide a report of the audit results to the QA committee monthly for 12 months.

Compliance Date: August 24, 2013

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blades. She states she was unsure how the resident could have obtained the knife and afterwards she searched the room and nothing else sharp was found. She stated the CNA's did random checks through the resident drawers on the locked unit where Resident #13 resided but not daily checks or scheduled checks.

Phone interview, on 07/10/13 at 2:10 PM, with Resident #13's son revealed the Social worker had notified him that the resident had the knife. He stated it was a small pen knife that the resident used when she/he was at home to clean her/his fingernails. He further stated the knife must have been in the resident's belongings when the resident was admitted to the facility on 03/25/13 to the Rehab Unit. Continued interview revealed the resident was later moved to the locked unit.

Interview, on 07/10/13 at 3:33 PM, with CNA #6 revealed she had admitted the resident to the Rehab Unit and did an inventory of her/his belongings and no knife was found.

Interview, on 07/10/13 at 4:00 PM, with Registered Nurse (RN) #1 revealed she had admitted the resident from the Rehab unit to the locked unit on 04/23/13 and she did not see a knife in her/his belongings.

Interview, on 07/10/13 at 5:40 PM, with the Assistant Director of Nursing (ADON), revealed she did not know anything about the pocket knife until this survey. She stated her expectation would be that the facility should have done an investigation to determine where the knife came from. She stated if she had known about the

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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(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
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knife she would have ensured the unit was safe and free of sharps with a room check. Continued interview revealed an Incident/Accident Form should have been implemented so the department heads were made aware. She stated the weekend nurse who found the knife, which was LPN #4, should have documented the incident on the Twenty-Four (24) Hour Report and the knife incident should have been discussed in the morning stand up meeting. She stated a room check was done on the locked unit every two (2) weeks and also the CNA or nurse screened belongings during admission.

Interview, on 07/10/13 at 6:15 PM, with the Social Worker revealed she was unsure of which nurse brought her the knife and she did not write any documentation regarding the knife in the resident's medical record or on an Incident Report. She stated she called the resident's son and let him know the knife was found and the son told her it probably fell out of his pocket. The Social Worker stated she did not notify administrative staff of the knife incident. She stated she attended the stand up meetings each morning and during the meetings the events on the Twenty-Four Hour Report were discussed; however, she did not remember this incident being brought up in the meetings. Continued interview revealed she did not complete Incident Reports and the nurse who found the knife should have completed the Incident Report.

Interview, on 07/10/13 at 6:20 PM, with the Director of Nursing (DON) revealed she had only been in the position as DON for a week. She stated her expectation would be that an Incident Report would be completed, an investigation

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would be done to determine the root cause of the resident having the knife and administrative staff should be notified.

2. Further review of Resident #13's medical record revealed a Nurse's Note dated 07/01/13 at 10:30 PM stating the nurse was doing rounds when noting Resident #13 was pushing buttons to the tube feeding pump machine of the roommate (Resident #17). The nurse explained to the resident she/he was not to touch the machine and the night shift supervisor was notified.

A Nurse's Note dated 07/02/13 at 10:10 PM revealed Resident #13 was having increased agitation and yelling out for her/his roommate (Resident #17) to get out of the room. Per the note, the nurse walked in the room and noted Resident #13 was pushing buttons on Resident #17's tube feeding machine. Resident #13 stated, this man is trying to get me. The nurse explained to Resident #13 that the pote was a feeding tube pump, not a man and she/he would be okay. The Note further stated, Resident #13 was difficult to re-direct and kept yelling at roommate.

Review of the Care Plan, update 07/03/13, for Resident #13 revealed the resident had a problem of disruptive behavior, could be agitated with others, and was resistive to care. The goal stated the resident would not cause injury to self or others. The interventions included; observe for changes in behavior, be aware of the tendency to get up at night and rummage and ensure safety of resident and others, observe for problems related to a recent new roommate and address problems as they arise. However, there was no

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reference on Resident #13's Plan of Care of the behaviors of pushing buttons on the tube feeding machine for Resident #17; and no interventions to address these behaviors.

Review of Resident #17's medical record revealed the resident was admitted to the facility on 06/05/13 with diagnoses of Intestinal Obstruction, Status/Post Peg Placement (percutaneous endoscopic gastrostomy), and Alzheimer's Dementia. Further review revealed on 07/10/13 the resident was moved to the locked unit. Review of the Admission Minimum Data Set (MDS) Assessment dated 06/12/13 revealed the facility had assessed the resident as having a Brief Interview of Mental Status (BIMS) of a five (5) indicating cognitive impairment. The MDS further revealed the facility assessed the resident as requiring the extensive assist of two (2) staff for transfers, and the extensive assist of one (1) staff for ambulation.

Review of Resident #17's Plan of Care, revealed no reference to the roommate (Resident #13) pushing the buttons of the tube feeding machine and no approaches to prevent reoccurrence.

Review Resident #17's Physician's Orders dated 07/13 revealed orders for Diabetesource AC from 7:00 PM until 9:00 AM at 75 milliliters per hour.

Interview, on 07/10/13 at 12:17 PM, with CNA #8 revealed she was frequently assigned to Resident #13 and had not seen her/him around Resident #17's tube feeding pump recently; however, had seen Resident #13 fiddling with Resident #17's tube feeding tubing in the past.

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Interview, on 07/10/13 at 12:39 PM, with LPN #2 revealed Resident #17 was only recently moved to the locked unit on 07/02/13 and there was concerns among the staff about how the room arrangement would work because Resident #13 had the room to herself/himself for a long time. She stated she worked a lot of evening shifts and had never witnessed Resident #13 to bother Resident #17's tube feeding pump and stated Resident #17 only received tube feedings from 7:00 PM until 9:00 AM and Resident #17 was not in her/his room during the day. She stated she was aware there had been concerns related to Resident #13 bothering Resident #17's tube feeding pump and staff was trying to figure out what would work best because most of the residents on the locked unit were mobile. Continued interview revealed staff had tried placing a pillowcase over Resident #17's tube feeding pole at first; however, that did not work because Resident #13 thought it was a person. She further stated the tube feeding rate on the machine could not be changed unless the buttons were held for a period of time and there was a sequence of buttons to push to change the rate. Further interview revealed there was no special monitoring of Resident #13 or Resident #17 after the incidents where Resident #13 was noted to push the tube feeding buttons.

Interview, on 07/10/13 at 3:35 PM, with CNA #9 revealed she checked on all the residents every fifteen (15) to twenty (20) minutes; however, there was no special monitoring for Residents #13 and #17. She stated she had never witnessed Resident #13 to bother Resident #17's tube feeding.

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Interview, on 07/10/13 at 4:00 PM, with RN #1 revealed she worked the evening shift and she had witnessed and reported to the night shift supervisor that Resident #13 was touching Resident #17's tube feeding pump. She stated the care plan was not revised for any special monitoring for Resident #13 and #17; however, she was up and down the hall at the time. Continued interview revealed the CNA's were to also monitor and let the nurses know if there was a concern. She stated Resident #17 was also able to let staff know if anyone bothers her/him.

Interview, on 07/10/13 at 4:09 PM, with CNA #2 revealed the residents were monitored hourly after they were in bed. She stated Resident #17 would let staff know if Resident #13 rummaged through her/his dresser drawers.

Interview, on 07/10/13 at 4:41 PM, with the Unit Manager on the locked unit, revealed she was aware that Resident #13 had touched Resident #17's tube feeding pump and staff had manipulated the pole to hide behind the curtain and a pillowcase was applied over the tube feeding to camouflage the pump. She stated she was unaware of Resident #13 touching the tube feeding tubing. She further stated it was documented on the 24 Hour Report when Resident #13 had touched the pump. Continued interview revealed the nurses were required to read the 24 Hour Report and convey the information to the CNA's. She stated the care plans for Resident #13 and #17 should have been addressed with revisions after the occurrences on 07/01/13 and 07/02/13. She stated any nurse could have revised the care plans including her or the ADON who was serving as the interim DON.

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until last week when the new DON started. She further stated the care plans should have been revised to show the behaviors and the interventions which were placed such as the pillow case on the pole and manipulation to hide the pole. Further interview revealed she had not thought about more frequent monitoring of the residents and staff felt this was just something that occurred during the adjustment period of receiving a new roommate. She stated she had not heard anything else from staff and there had not been anything else on the 24 Hour Report since the two (2) occurrences which were documented in the Nurse's Notes.

F 323

Interview, on 07/10/13 at 5:40 PM, with the ADON revealed the nurses and the Nurse Manager were checking on Resident #13 and #17 more frequently and at least hourly, and they had tried putting a pillow case over the tube feeding pump which did not work. She stated they discussed the issue in the stand up meeting and felt this was an adjustment period for Resident #13 and she/he needed time to get used to a roommate. Continued interview revealed she was unaware Resident #13 had ever pulled on the tube feeding tubing and stated the administrative staff should have had more discussion with the night nurses to understand what they were seeing. She stated the care plans for both residents should have been revised to include the interventions they had tried such as at least hourly checks and putting the pillow case over the pole. Further interview revealed since the concern was noted with this survey they had rearranged the beds in the room and asked Resident #17 if she/he wanted a room change which she/he declined.

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Interview, on 07/10/13 at 6:20 PM, with the DON revealed she had only been in that position for a week. She stated her expectation would be for frequent monitoring of the residents and she would also expect documentation in the nurses care plans of behaviors and interventions as needed. Further interview revealed there should have been education/in-servicing for the staff related to what was expected to prevent reoccurrence.

F 323

F 371 483.35(i) FOOD PROCURE,
SS=F STORE/PREPARE/SERVE - SANITARY

F 371 1) All items noted in the surveyor report were corrected.

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

2) All residents have the potential to be affected. An audit of the facility's kitchen, food service equipment, storage areas, refrigerators, freezers and ice dispensing machines was completed by the Registered Dietitian on July 31, 2013. Any areas of non-compliance will be addressed.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of facility policies, it was determined the facility failed to ensure food was stored, prepared, distributed, and served under sanitary conditions.

3) The Food Service Director will ensure monthly sanitation audits of the food service facilities and areas noted on the survey report are completed for 12 months. The Food Service Director will ensure any

Observation on initial tour of the kitchen 07/08/13 revealed a dietary staff member with a beard and no beard cover was preparing turkey and cheese sandwiches at the prep area. Also, the walk in refrigerator revealed a bag of turkey sausage which was unlabeled and undated and the steam table pans were noted to be stored wet.

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In addition, observation of tray line on 07/08/13 revealed the server who was plating food, brushed his apron with his gloved hands, and then donned a new pair of gloves over the soiled gloves and continued to serve food on the tray line.

The findings include:

Review of the facility's, "Dishwashing Procedures" Policy, undated, revealed it was the policy of the facility to properly sanitize dishes and to establish systems to avoid the improper handling of dishware. Further review revealed, cleaned dishes must be allowed to air dry before storage. The Policy stated, warm water was an excellent medium for the growth of bacteria.

Review of the facility's, "Refrigerated Storage" Policy, undated, revealed it was the policy of the facility to store, prepare, and serve foods in accordance with federal, state, and local sanitary codes. Further review revealed all foods will be properly wrapped and/or stored in sealed containers and dated and labeled.

Review of the facility's, "Hand Washing Procedures" Policy, undated, revealed it was the policy of the facility to prevent the transmission of bacteria. Proper handwashing would be used to eliminate the source of some of the bacteria in a food service department.

1. Observation on initial tour, on 07/08/13 at 1:40 PM, revealed steam table pans were stored wet on a shelf. In addition, a bag of turkey sausage which was unlabeled and undated was noted in

F 371

identified, non-compliant areas noted on this audit will be addressed. Lastly, on August 7, 2013 the Food Service Director will re-educate all food service staff on the storage, preparation, distribution and serving of food standards referenced in the survey report (EXHIBIT 3).

4) The Food Service Director will provide a report to the QA committee monthly for 12 months related to the audit findings and necessary interventions.

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F 371 Continued From page 19
the walk in refrigerator.

F 371

Interview, on 07/10/13 at 2:00 PM, with the Dietary Manager revealed steam pans should be completely dry before stored and were to be air dried. She further stated all foods should be labeled and dated prior to placing in the refrigerator and she had inserviced staff on this in the past. She further stated when new stock arrived she checked the refrigerators for any foods which were unlabeled or undated and inserviced staff as needed.

2. Further observation on initial tour, on 07/08/13 at 2:20 PM, revealed Dietary Staff Member #1 was preparing turkey and cheese sandwiches at the prep area. He was noted to have a beard and no beard cover. Interview with the Dietary Manager at the time of the observation revealed Dietary Staff Member #1 had just returned from vacation and she had not noted he had grown a beard; however, stated the beard should be covered.

interview, on 07/08/13 at 2:25 PM, with Dietary Staff Member #1 revealed he did not have to have a beard cover as long as his beard was groomed.

3. Observation, on 07/08/13 at 4:50 PM, of the supper tray line revealed the server was using gloved hands to scoop food and to cut and place sandwiches on plates. The server was noted to brush his apron with his gloved hands, then placed another pair of gloves over the soiled gloves. The server continued to serve food.

Interview, on 07/10/13 at 2:00 PM, with the

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F 371	<p>Continued From page 20</p> <p>Dietary Manager, revealed if the server touched his apron, he should have removed the soiled gloves and washed his hands before donning new gloves and continuing to serve food.</p> <p>Interview, on 07/10/13 at 8:45 AM, with the Registered Dietician revealed she completed a monthly sanitation check and observed for proper food handling/food storage. She stated staff was to date and label all foods before placing them in the refrigerator. Continued interview revealed pans were to be completely dry prior to storing and staff with beards should have beard covers. She further stated if a food server touched his apron, he should have washed his hands, and then donned new gloves before continuing to serve the food.</p>	F 371		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in</p>	F 431	<ol style="list-style-type: none"> 1) The facility has an existing system and policies for the administration of medications. The medications were removed from Resident # 16's room on 7/10/13. The nurse identified in the report received disciplinary action related to her violation of the facility's existing policy. 2) Residents that were part of the identified nurse's assignment had the potential to be affected. All resident rooms on the 	

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locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to ensure proper storage of drugs and biologicals for one (1) of twenty-two (22) sampled residents (Resident #16).

Observation during medication pass revealed Resident #16's medications including Advair Diskus and Flonase Spray were left unattended on Resident #16's bedside table.

The findings include:

Review of the facility's, "Storage of Medications" Policy, undated, revealed medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply was accessible only to licensed nursing personnel, pharmacy personnel,

F 431: identified nurse's assignment were audited on July 10, 2013. No areas of non-compliance were identified.

3) The identified nurse will be re-educated on the facility's existing medication administration policy. The identified CMT will be re-educated on the facility's reporting practices for non-compliance to the medication administration policy. This re-education will be done by the Director of Nursing. Lastly, the Staff Development Coordinator will conduct a sample audit of a minimum of six medication passes monthly for 12 months.

4) The DON will provide a report to the QA committee monthly for 12 months on the completed audits and associated actions.

Compliance Date: August 24, 2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 431 Continued From page 22
or staff members lawfully authorized to administer medications.

F 431

A review of the medical record for Resident #16 revealed the facility re-admitted the resident on 12/12/11 with diagnoses which included Hypertension, Bipolar Disorder, Dementia and Chronic Obstructive Pulmonary Disease. A review of the Physician's Orders dated July 2013 revealed orders for Advair Diskus (a medication for respiratory symptoms inhaled through the mouth), one (1) puff two (2) times per day and Flonase (a medication sprayed in the nostrils for allergy symptoms), one (1) spray in each nostril two (2) times per day. Further review of the Physician's Orders did not reveal documented evidence Resident #16 had an order to keep medications at the bedside.

Observation, on 07/10/13 at 8:45 AM, of a medication pass revealed Resident #16's Advair and Flonase were on the resident's bedside table when Certified Medication Technician (CMT) #1 went into the resident's room to administer the residents medication.

Interview, on 07/10/13 at 8:57 AM, with CMT #1 revealed Resident #16's Flonase and Advair were often on the resident's bedside table when the CMT went into the resident's room to administer the morning medications. The interview further revealed the resident's medications should not be left at the bedside and the CMT always placed the medications back into the medication cart when found at the bedside.

Interview, on 07/10/13 at 1:05 PM, with Resident #16 revealed the night shift nurse often left the

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F 431 Continued From page 23

Advair and Fionase on the bedside table at night after the medication was administered. The interview further revealed the morning nurse that came to administer the morning medications administered the Flonase and Advair and then removed the medications from the resident's room.

Interviews, on 07/10/13 with the Unit Manager (UM) at 1:32 PM, the Assistant Director of Nursing (ADON) at 1:40 PM and Licensed Practical Nurse (LPN) #1 at 1:47 PM revealed Resident #16 was not assessed to be able to self administer medications and the resident's medications should not be left at the resident's bedside.

Interview, on 07/10/13 at 6:20 PM, with Licerised Practical Nurse (LPN) #3 revealed the LPN did remember accidently leaving the resident's Flonase and Advair on the bed side table but denied leaving the medications on the bedside table after each administration. The interview further revealed the LPN became distracted assisting another resident and forgot to pick up Resident #16's medcations from the bedside table. The LPN stated Resident #16's medications should not be left at the resident's bedside.

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1984

SURVEY UNDER: 2000 Existing

FACILITY TYPE: S/NF DP

TYPE OF STRUCTURE: Two (2) stories with a full basement, Type II unprotected.

SMOKE COMPARTMENTS: Five (5) smoke compartments on the first and second floors and three (3) in the basement.

FIRE ALARM: Complete fire alarm system with heat and smoke detectors.

SPRINKLER SYSTEM: Complete automatic, wet sprinkler system, hydraulically designed.

GENERATOR: Type II, 155 KW generator. Fuel source is diesel.

A standard Life Safety Code survey was conducted on 07/09/13. Christian Health Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

K 000 The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/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 of federal and state law.

RECEIVED
AUG - 2 2013
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Raymond A. D. J.</i>	TITLE Senior Executive Director	(X6) DATE 8/2/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000 Continued From page 1
Deficiencies were cited with the highest deficiency identified at F level.

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments on the first floor, approximately twelve (12) residents, staff and visitors. The facility has one-hundred and eighteen (118) certified beds, and the census was one-hundred and thirteen (113) on the day of the survey.

The findings include:

Observations, on 07/09/13 at 8:25 AM, with the Maintenance Director revealed the door to the Medical Records Room located within the

K 000

K 029.

- 1) The two doors identified were equipped with self-closing devices by the Maintenance Director.
- 2) All applicable doors as described in NFPA 101-19.3.2.1 will be audited by the Maintenance Director.
- 3) The Maintenance Director was educated on NFPA 101-19.3.2.1 by the Administrator on July 30, 2013. An indicator for the auditing of compliance of applicable doors protecting hazards will be added to the facility's existing QA program. The audits will be completed by the Maintenance Director or designee monthly for 12 months.
- 4) The Maintenance Director will collect this indicator's data and provide a report to the QA Committee monthly for 12 months.

Compliance Date: August 24, 2013

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K 029: Continued From page 2 K 029:

Medical Records Office, did not have a self-closing device installed on the door. Further observation revealed the door to the new Medical Records Room, adjacent to the Office was not equipped with a self-closing device.

Interview, on 07/09/13 at 8:25 AM, with the Maintenance Director revealed he was not aware of the Medical Records Rooms being categorized as a hazardous storage areas and the requirement for the doors to be equipped with a self-closing device. Further interview revealed the new Medical Records Rooms had recently been converted from an office.

Reference:
NFPA 101 (2000 Edition).

- 19.3.2 Protection from Hazards.
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:
- (1) Boiler and fuel-fired heater rooms
 - (2) Central/bulk laundries larger than 100 ft² (9.3 m²)
 - (3) Paint shops

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K 029 Continued From page 3
 (4) Repair shops
 (5) Soiled linen rooms
 (6) Trash collection rooms
 (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction
 (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K 029

K 038 SS=F NFPA 101 LIFE SAFETY CODE STANDARD
 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

K 038

- 1) The three doors identified were updated to display the required, contrasting signage on July 15, 2013.
- 2) An audit of all delayed egress, exit doors was completed on July 10, 2013 by the Maintenance Director to assess that required, contrasting signage was present.
- 3) Any identified doors that required updated signage were corrected on July 15, 2013 by the Maintenance Director. The Maintenance Director was educated on NFPA 7.2.1.6.1 (d) by the

This STANDARD is not met as evidenced by:
 Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect all thirteen (13) smoke compartments on the basement, first and second floors, and all residents, staff and visitors. The facility has one-hundred and eighteen (118)

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K 038 Continued From page 4
certified beds and the census was one-hundred and thirteen (113) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had the proper signage displayed.

The findings include:

Observations, on 07/09/13 between 9:08 AM and 12:05 PM, with the Maintenance Director revealed the doors to each of the three (3) stairwell exits on the basement, first and second floors were equipped with delayed egress locks, but did not display the proper signage on the doors.

Interviews, on 07/09/13 between 9:08 AM and 12:05 PM, with the Maintenance Director revealed he was not aware of the requirement for delayed egress doors to display the proper signage for exiting.

Reference:

NFPA 101 (2000 edition)

7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through

K 038

Administrator on August 2, 2013. In addition, an indicator was created for the facility's existing QA program to audit compliance of delayed egress, exit door signage for 12 months.

- 4) The Maintenance Director will collect this indicator's data and provide a report to the QA Committee monthly for 12 months.

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K 038 Continued From page 5
42, provided
that the following criteria are met.

(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.

(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.

(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.
Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.

(d) On the door adjacent to the release device,

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K 038	Continued From page 6 there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038		
K 050 SS-F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure fire drills	K 050	1) The facility does have a policy and procedure for conducting fire response drills for all shifts. Fire drills from March 2013 to present have been completed and are in compliance with this standard. The facility has conducted 14 fire drills from October 2012 to present. 2) All residents have the potential to be affected.	

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K 050 Continued From page 7
were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect each of the thirteen (13) smoke compartments on the basement, first and second floors, residents, staff, and visitors. The facility has one-hundred and eighteen (118) certified beds and the census was one-hundred and thirteen (113) on the day of the survey.

The findings include:
Record review, on 07/09/13 at 1:45 PM, with the Maintenance Director revealed the facility had no documentation of fire drills being conducted during the first shift in the third quarter of 2012 and during the third shift in the first quarter of 2013.
Interview, on 07/09/13 at 1:45 PM, with the Maintenance Director revealed he was not aware of fire drills not being conducted at a minimum of one per shift per quarter.

Reference: NFPA Standard NFPA 101 19.7.1.2.
Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.

K 062 SS-D 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, 9.7.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was

K 050 3) The facility implemented a revised tracking grid (EXHIBIT 1) to assure fire drills occur per NFPA 101-19.7.1.2 standards. The Maintenance Director will audit fire drill reports monthly to ensure the correct shift has participated in a fire drill each quarter. The Maintenance Director was re-educated on this standard by the Administrator on August 2, 2013.

4) The Maintenance Director will collect this audit data and provide a report to the QA Committee monthly for 12 months.

K 062 Compliance Date: August 24, 2013

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K 062 Continued From page 8
determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect all thirteen (13) smoke compartments on the basement, first and second floors, residents, staff and visitors. The facility has one-hundred and eighteen (118) certified beds and the census was one-hundred and thirteen (113) on the day of the survey.

The findings include:

Observation, on 07/09/13 at 12:30 PM, with the Maintenance Director revealed the facility failed to provide a sprinkler wrench and a sufficient amount of replacement heads available for the sprinkler system.

Interview, on 07/09/13 at 12:30 PM, with the Maintenance Director revealed he was not aware the wrench was removed from the storage box and an insufficient amount of replacement heads were available for replacement, if needed. NFPA requires a minimum of two (2) replacement heads for each type of head installed in the sprinkler system.

Reference: NFPA 13 (1999 edition)

6.2.9.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed.

- K 062
- 1) The sprinkler wrench and one, additional spare sprinkler head were placed in the facility's sprinkler storage box on July 15, 2013 by Kentuckiana Sprinkler, Inc. and the Maintenance Director. The box contained 5 spare sprinkler heads at the time of inspection.
 - 2) The facility has only one sprinkler storage box. No other area could be affected.
 - 3) A complete audit of the facility sprinkler box was completed on July 15, 2013 by the Maintenance Director. All required items were present in the sprinkler box. An indicator was created for the facility's existing QA program for an audit of the sprinkler box monthly to ensure all required components are present. The Maintenance Director will complete this audit monthly for 12 months.

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(X4) IC PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IC PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 066 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the two (2) designated outdoor smoking areas, one (1) for Residents and one (1) for Staff, were properly equipped for safe smoking, in accordance with NFPA standards. The deficiency had the potential to affect residents, staff and visitors. The facility has one-hundred and eighteen (118) certified beds and the census was one-hundred and</p>	K 066	<p>4) The Maintenance Director will collect this audit data and provide a report to the QA Committee monthly for 12 months.</p> <p>Compliance Date: August 24, 2013</p> <p>1) The outside resident smoking area was equipped with an ash pot, fire blanket and fire extinguisher on August 2, 2013. The outside staff smoking area was equipped with an ash pot and fire extinguisher on August 2, 2013.</p> <p>2) Areas identified in the report are the only two, designated smoking areas. No other areas have the potential to be affected.</p> <p>3) The department directors, unit managers and house supervisors will be educated on NFPA 19.7.4</p>

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K 066	Continued From page 10 thirteen (113) on the day of the survey. The findings include: Observations, on 07/09/13 between 9:03 AM and 9:13 AM, with the Maintenance Director revealed the designated, outdoor smoking area for Residents did not have an approved metal container with a self-closing lid to empty the ash trays into, a fire extinguisher and a fire blanket readily available for usage. The designated outdoor smoking area for the Staff, did not have an approved metal container with a self-closing lid to empty ashtrays into and a fire extinguisher available for usage. Interview, on 07/09/13 between 9:03 AM and 9:13 AM, with the Maintenance Director revealed he was not aware of the requirements of the designated, outdoor smoking areas to have an approved metal container with a self-closing lid to empty ash trays, a fire extinguisher and a fire blanket readily available for usage. Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location.	K 066	(2, 3 and 4) by the Maintenance Director or Administrator. In addition, an indicator will be created for the facility's existing QA program to audit the presence of required containers, blankets and fire extinguishers at designated smoking areas. This audit will be completed by the Maintenance Director monthly for 12 months. 4) The Maintenance Director will collect this audit data and provide a report to the QA Committee monthly for 12 months. Compliance Date: August 24, 2013	
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K 066 Continued From page 11
and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
(2) Smoking by patients classified as not responsible shall be prohibited.
Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.
(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

K 066

Reference: S & C Letter: 12-04-NH;
Date: November 10, 2011
Subject: Alert: Smoking Safety in Long Term Care Facilities

K 143 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
Transferring of oxygen is:
(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour

K 143

1) The outlets identified in the report were removed and replaced with covers on July 12, 2013.

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K 143: Continued From page 12
fire-resistive construction;

(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and

(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2

K 143
2) The outlets were located in the only oxygen storage room within the facility. No other areas could be affected.
3) The Maintenance Director was re-educated on NFPA 99-4-3.1.1.2 (a). An audit of the oxygen storage room was conducted by the Maintenance Director of July 12, 2013. An indicator will be revised for the facility's existing QA program to audit the oxygen room to assure any electrical outlet(s) are compliant. This audit will be completed by the Maintenance Director monthly for 12 months. The Maintenance Director was re-educated on NFPA 99-4-3.1.1.2 (a) on August 2, 2013 by the Administrator.
4) The Maintenance Director will collect this audit data and provide a report to the QA Committee monthly for 12 months.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the oxygen storage room was protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments on the second floor, approximately twelve (12) residents, staff and visitors. The facility has one-hundred and eighteen (118) certified beds and the census was one-hundred and thirteen (113) on the day of the survey. The facility failed to ensure the room used for transferring oxygen did not have any electrical devices mounted less than five (5) feet above the floor.

The findings include:

Observation, on 07/09/13 at 10:02 AM, with the Maintenance Director revealed the storage room

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K 143	<p>Continued From page 13</p> <p>used to transfer oxygen had two (2) duplex receptacles installed below five (5) feet from the floor.</p> <p>Interview, on 07/09/13 at 10:02 AM, with the Maintenance Director revealed he was unaware the duplex receptacles could not be installed below five feet from the floor if the storage room was used to transfer oxygen.</p> <p>Reference: NFPA 99 (1999 edition).</p> <p>4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity, In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be p for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases</p>	K 143	

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K 143	<p>Continued From page 14</p> <p>shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose.</p> <p>3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.</p> <p>4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches and receptacles shall be installed in fixed locations not less than 152 cm (5 feet) above the floor as a precaution against their physical damage.</p> <p>5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [also 4-3.1.1.2(a) 7].</p> <p>6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat.</p> <p>7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders.</p> <p>8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.</p> <p>9. Containers shall not be stored in a tightly closed space such as a closet [8-2.1.2.3(c)].</p> <p>10. Location of Supply Systems. a. Except as permitted by 4-3.1.1.2(a) 10c, supply systems for medical gases or mixtures of</p>	K 143		
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K 143	Continued From page 15 these gases having total capacities (connected and in storage) not exceeding the quantities specified in 4-3.1.1.2(b) 1 and 2 shall be located outdoors in an enclosure used only for this purpose or in a room or enclosure used only for this purpose situated within a building used for other purposes. b. Storage facilities that are outside, but adjacent to a building wall, shall be in accordance with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites. c. Locations for supply systems shall not be used for storage purposes other than for containers of nonflammable gases. Storage of full or empty containers shall be permitted. Other nonflammable medical gas supply systems or storage locations shall be permitted to be in the same location with oxygen or nitrous oxide or both. However, care shall be taken to provide adequate ventilation to dissipate such other gases in order to prevent the development of oxygen-deficient atmospheres in the event of functioning of cylinder or manifold pressure-relief devices. d. Air compressors and vacuum pumps shall be located separately from cylinder patient gas systems or cylinder storage enclosures. Air compressors shall be installed in a designated mechanical equipment area, adequately ventilated and with required services. a. Walls, floors, ceilings, roofs, doors, interior finish, shelves, racks, and supports of and in the locations cited in 4-3.1.1.2(a) 10a shall be constructed of noncombustible or limited-combustible materials. b. Locations for supply systems for oxygen, nitrous oxide, or mixtures of these gases shall not	K 143	

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K 143	Continued From page 16 communicate with anesthetizing locations or storage locations for flammable anesthetizing agents. c. Enclosures for supply systems shall be provided with doors or gates that can be locked. d. Ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5ft (1.5 m) above the floor to avoid physical damage. e. Where enclosures (interior or exterior) for supply systems are located near sources of heat, such as furnaces, incinerators, or boiler rooms, they shall be of construction that protects cylinders from reaching temperatures exceeding 130°F (54°C). Open electrical conductors and transformers shall not be located in close proximity to enclosures. Such enclosures shall not be located adjacent to storage tanks for flammable or combustible liquids. f. Smoking shall be prohibited in supply system enclosures.	K 143		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments on the first floor, approximately twelve (12) residents, staff, and visitors. The facility has one-hundred	K 147	1) The power strip identified in the report was corrected on July 9, 2013. 2) An audit of resident rooms, offices and common areas will be completed by the Maintenance Director to determine if any other areas are affected. 3) Any identified areas of non-compliance will be corrected by the Maintenance Director. In addition, the Business Office Manager will be re-	

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K 147

Continued From page 17
and eighteen (118) certified beds and the census was one-hundred and thirteen (113) on the day of the survey.

The findings include:

Observation, on 07/09/13 at 8:07 AM, with the Maintenance Director revealed, in the first floor Business Office, a refrigerator, a microwave and a coffee pot were plugged into a power strip.

Interview, on 07/09/13 at 8:07 AM, with the Maintenance Director revealed he was aware of the requirements for the usage of power strips; however, he was not aware that a refrigerator, a microwave and a coffee pot were plugged into a power strip in the Business Office.

Reference: NFPA 99 (1999 edition)
3-3.2.1.2 D

Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.

K 147

educated on the electrical code standards by the Maintenance Director. An indicator will be created for the facility's existing QA program to audit for the presence of any non-compliant power strips or electrical devices. This indicator will sample a minimum of 4 offices and 10 resident areas monthly and be completed by the Maintenance Director.

- 4) The Maintenance Director will collect this audit data and provide a report to the QA Committee monthly for 12 months.

Compliance Date: August 24, 2013