

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

PRINTED: 10/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2012
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220		
(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 A standard health survey was initiated on 10/09/12 and concluded on 10/11/12 and a Life Safety Code survey was initiated and concluded on 10/09/12. Deficiencies were cited with the highest scope and severity of an E. The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.		
F 205 SS=C	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy on Notice of Transfer/Discharge, it was determined the facility	F 205	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F205 It is the practice of this facility to ensure before a resident transfers to a hospital or goes on a therapeutic leave, that we provide written information to the resident and a family member or legal representative that specifies – (i) the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and (ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b) (3) of this section, permitting a resident to return.		

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

TITLE ~

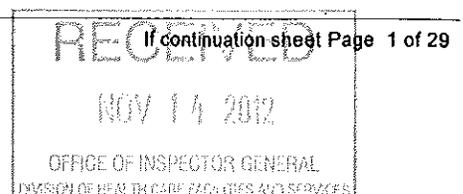
(X8) DATE

X Joseph Barrett

X Administrator

X 11/14/2012

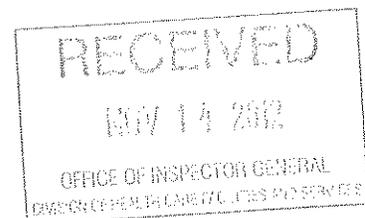
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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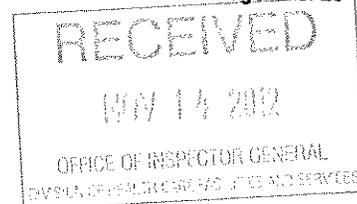
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F 205	<p>Continued From page 1</p> <p>failed to ensure residents leaving the facility for physician appointments, emergency room visits and hospital procedures were provided with a Notice of Transfer/Discharge for eight (8) of twenty-four (24) sampled residents and twelve (12) unsampled residents. (Residents #4, #10, #14, #15, #18, #22, #23 and #24).</p> <p>The findings include:</p> <p>The facility did not provide evidence of a policy regarding Transfer/Discharge.</p> <p>Interview with the Director of Nursing (DON), on 10/11/12 at 3:45 PM, revealed the facility did not provide residents' transferring from the facility for emergency room visits, hospital visits and physician appointment visits with a Notice of Transfer/Discharge.</p> <p>1. Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Multiple Injuries related to a MVA in 2011. The facility transferred the resident to the hospital for care on 07/26/12, 08/10/12, 08/24/12 and 09/19/12. The facility was not able to provide documentation the resident received a Notice of Transfer for any of these transfers.</p> <p>2. Review of the clinical record for Resident #10, revealed the facility admitted the resident with diagnoses of Congestive Heart Failure and Chronic Renal Disease. The facility transferred the resident to the hospital for care after a fall on 09/09/12. On 09/10/12, the facility transferred the resident back to the hospital for testing. On 09/11/12, the facility transferred the resident back to the hospital and the resident was admitted.</p>	F 205	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Resident #4, #10, #18, #24 still reside in the facility.</p> <p>Residents identified were educated and provided with a Bed-Hold Notice form by Social Services on or before 11/18/2012. Resident's #14, #15, #22 and #23 no longer reside in the center.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice?</p> <p>Current residents and new admissions have the potential to be affected by the deficient practice.</p> <p>Current residents will be educated on requirement of Bed-Hold Notice upon discharge to an acute care setting, therapeutic leave or physician appointment on or before 11/18/2012. An audit was completed of residents discharged to an acute care setting, therapeutic leave or physician appointment since 10/11/12 to ensure a Bed-Hold Notice form was completed and sent with the resident on or before 11/18/2012 by Social Services. Residents who did not have a Bed-Hold Notice form at time of transfer will be provided with a copy of the Bed-Hold Notice form and educated on the purpose of the form on or before</p>		



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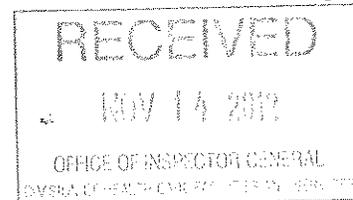
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F 205	<p>Continued From page 2</p> <p>The facility was unable to provide documentation of providing the resident with Notice of Transfer/Discharge for any of those transfers.</p> <p>3. Review of the clinical record for Resident #14, revealed the facility admitted Resident #14 with diagnoses of Malnutrition and Alcohol Abuse. The facility transferred the resident to the hospital for a physician 's appointment on 09/05/12. The facility was unable to provide documentation of the resident receiving a Notice of Transfer for that transfer.</p> <p>4. Review of the closed records for Resident #22, #23, and #24 revealed none had a Notice of Transfer/Discharge when they were each discharged from the facility.</p> <p>5. Review of the clinical record for Resident # 15, revealed the facility admitted Resident #15 on 07/21/07 with a diagnosis of Hypertension, Dementia and Syncopal episode related to severe aortic stenosis. The facility transferred the resident on 07/12/12 to the Hospital for Shortness of Air. The facility was unable to provide documentation of the resident receiving a Notice of Transfer for that transfer.</p> <p>6. Review of clinical record for Resident #18, revealed the facility admitted Resident #18 with diagnoses of Chronic Renal Failure, Anemia, Pneumonia, and Cardiac Disease on 02/09/08. The facility transferred the resident to the hospital for acute care and re-entered the facility on 11/28/11. The facility was unable to provide documentation on the resident receiving a Notice of Transfer for those transfers.</p>	F 205	<p>11/18/2012 by Social Services.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur – To ensure the deficient practice will not recur, the facility has implemented the use of a standardized Bed-Hold Notice Form. The Interdisciplinary team consisting of the Administrator, the Administrative Director of Nurses (ADNS), Social Workers, and Directors of Care Delivery (DCD) will monitor completion of the Bed-Hold Notice Form daily through the Eagle Room Quality Assessment and Assurance process to ensure compliance beginning on 11/14/2012.</p> <p>Licensed Nurses and Social Services will be inserviced by Administrator, Assistant Administrator, Human Resources Director and Nurse Supervisor on the Bed-Hold Notice policy by 11/18/2012. Questionnaire will be provided to nurses and Social Services post education to validate competency.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained –A Bed-Hold Notice QAA Audit tool will be</p>		



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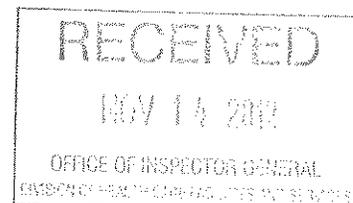
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F 205	Continued From page 3 Interview with Registered Nurse (RN) #2, on 10/11/12 at 11:00 AM, revealed she was not familiar with the Notice of Transfer/Discharge and the facility did not use such a form. Interview with Licensed Practical Nurse (LPN) #1, on 10/11/12 at 1:50 PM, revealed the facility did not have a Notice of Transfer/Discharge to send out with residents. Interview with the Administrator on 10/10/12 at 4:30 PM revealed the facility had not used a Notice of Transfer/Discharge letter for all residents transferred or discharged from the facility.	F 205	completed on resident transfers to the acute care center, MD appointments or on a therapeutic leave by Social Services to ensure the Bed-Hold Notice form is completed at time of transfer by the licensed nurses. Beginning 11/14/2012 this audit will be completed once a week for 4 weeks, monthly times 2 months and quarterly for 2 quarters. Areas of non-compliance will be addressed immediately.		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's orientation guidebook, it was determined the facility failed to provide care in a dignified manner for two (2) of twenty-four (24) sampled residents and twelve (12) unsampled residents. The facility failed to provide privacy during a skin assessment for Resident #6 which exposed him/her to the roommate's visitor. In addition, the facility staff failed to sit while feeding Resident #20. The findings include:	F 241	Audit results will be reviewed during our QAA process. The quality assessment and assurance (QAA) committee (Administrator, Assistant Administrator, ADNS, Medical Director, DCD, Social Services, Maintenance) will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012. 11/19/2012 F241 It is the practice of this facility 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.		



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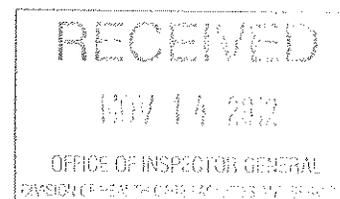
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F 241	Continued From page 4 Review of the facility's orientation guidebook, dated 2002, revealed it was necessary to knock before entering a resident's room because all residents deserve to be treated with dignity and respect. In order to promote a resident's dignity and respect, staff must always knock before entering the resident's room. 1. Observation of Resident #6, on 10/10/12 at 9:30 AM, during the resident's skin assessment, revealed Unit Manager Registered Nurse (RN) #1 entered the room and closed the resident's door. Further observation of Resident #6's room revealed no privacy curtain around the bed to shield the resident from being seen from the hallway. In addition, the privacy curtain between Resident #6 and the room-mate was only drawn halfway closed. Continued observation during the skin assessment revealed RN #1 left Resident #6's body exposed except when she entered the bathroom for a wash-cloth. Further observation revealed, the visitor for the roommate walked to the foot of the resident's bed, which allowed a visual view of Resident #6's body. At 4:40 PM, Certified Nursing Assistant (CNA) #2 entered the room without knocking while Resident #6's lower body was exposed. Interview with RN #1, on 10/10/12 at 10:00 AM, revealed all staff were trained to knock before entering a resident's room. She further stated as a manager daily rounds and consistent observations of staff knocking were ways she ensured privacy was maintained. She continued to state that CNA #2 entered the room during the skin assessment without knocking.	F 241	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - Privacy curtain was replaced for resident #6 by Director of Housekeeping on 10/10/2012. Resident #20 has been assessed to determine the level of assistance required for meals and ADL care plan has been revised on 11/9/2012 by DCD. During meal time, staff will sit and provide assistance to resident #20. How will you identify other residents having the potential to be affected by the same deficient practice? - Current residents and new residents have the potential to be affected. A facility wide audit was conducted for placement and function of privacy curtains by the Housekeeping Director on or before 11/9/2012. Rooms requiring placement and/or repair of privacy curtains will be corrected by the Housekeeping Director prior to 11/18/12. Residents who require assistance with feeding were assessed for level of assistance and ADL care plan updated		



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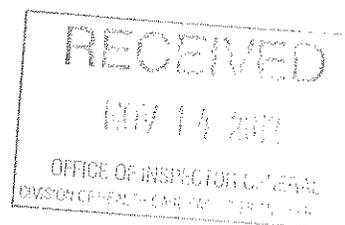
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F 241	<p>Continued From page 5</p> <p>Interview with CNA #2, on 10/10/12 at 11:45 AM, revealed she had been trained to knock before entering a resident's room. She further stated the purpose of knocking was to ensure the resident's dignity and respect. She stated she should have knocked before entering Resident #6's room.</p> <p>Additional interview with RN #1 on 10/10/12 at 12:00 PM, revealed Resident #6's privacy curtain had been removed by housekeeping to be cleaned prior to 10/10/12, however, she was unsure when Resident #6's privacy curtain was removed.</p> <p>Interview with Resident #6 in his room, on 10/10/12 at 10:45 AM, revealed he/she had never had a privacy curtain around his bed. He/She further stated that he/she was exposed whenever the door was opened and care was being provided.</p> <p>Record review revealed Resident #6 was assessed on the Minimum Data Set Assessment (MDS) dated 08/11/12 to have a BIMS score of 15 with no cognitive deficit. Further review of the MDS for Resident #6 revealed the resident required extensive assistance with personal care.</p> <p>2. The facility was unable to produce a policy or a checklist on feeding the residents.</p> <p>Resident #20 was observed during the evening meal in the Life Skills Dining Area, on 10/09/12 at 4:40 PM, being fed by Certified Nursing Assistant (CNA) #8. During that time CNA #8 was observed standing while feeding Resident #20. The Director of Nursing (DON) came into the dining area and offered the CNA a chair and</p>	F 241	<p>by the DCDs, MDS nurses or Nurse Supervisor on or before 11/18/12. Staff feeding residents that require assistance will sit while offering assistance.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? – Housekeeping staff will be educated by the Housekeeping Director on the need to ensure each resident has a privacy curtain and is in good repair on or before 11/12/12.</p> <p>Nursing staff and therapists assisting residents with meals will be inserviced by the Administrator, Assistant Administrator, Rehab Director, DCDs, Human Resources Director and Nurse Supervisor on the requirement to sit when providing assistance to residents during meals on or before 11/18/2012.</p> <p>C.N.A. #2 was educated one on one on our ADL/Restorative Practice guide by Director of Care Delivery on or before 11/09/2012.</p> <p>Nursing staff providing care for residents in their rooms will be inserviced by the Administrator, Assistant Administrator, Rehab</p>		



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F 241	<p>Continued From page 6 motioned him to sit down.</p> <p>Resident #20 was observed, on 10/10/12 at 11:45 AM, during the lunch meal in the Skills Dining area being fed by Registered Nurse (RN) #5 and CNA #6. The RN and the CNA were both observed standing over the resident while assisting with feeding.</p> <p>Interview with CNA #6, on 10/10/12 at 12:05 PM, revealed he had worked at the facility for fifteen (15) years and was uncertain whether the facility's policy was to sit or stand while feeding a resident.</p> <p>Interview with the Life Skills Coordinator, on 10/10/12 at 12:10 PM, revealed she had been in her position at the facility for ten (10) years and was uncertain what the facility's policy was concerning sitting or standing while assisting with feeding a resident.</p> <p>Interview with RN #5, on 10/10/12 at 12:30 PM, revealed she was trained to sit down when feeding a resident. RN #5 commented there was not an extra chair in the room and that standing while feeding might make a resident feel hurried. RN #5 was uncertain who was responsible to train the CNAs in the proper way of feeding the residents.</p> <p>Interview with RN #6, the Director of Clinical Delivery (DCD) for the Pathway Unit and the Skills Living Unit, on 10/10/12 at 2:30 PM, revealed all CNA's were trained in CNA school on feeding residents and were given a preceptor when hired. The proper way of feeding a resident was reviewed in the new employee orientation and also reviewed by the new employee's</p>	F 241	<p>Director, DCDs, Human Resources Director and Nurse Supervisors to ensure they understand the requirement to provide privacy during care and treatment on or before 11/18/12.</p> <p>To ensure the deficient practice does not recur as it relates to privacy curtains, Housekeeping staff will utilize a daily check off list to monitor for placement and function of privacy curtains beginning 11/12/2012. The daily check off list will be reviewed by the Housekeeping Director weekly and corrections made as they are identified.</p> <p>To ensure the deficient practice does not recur as it relates to sitting while feeding residents that require assistance, dining rooms will be monitored daily per each meal by nurse supervisor or meal monitors (Administrator, Assistant Administrator, Administrative Director of Nursing, Business Office, Activities, Social Services, Human Resources, Maintenance, Dietician, Nurse Supervisor, Weekend Manager). New hires will be educated in orientation on this new process.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?-</p>		

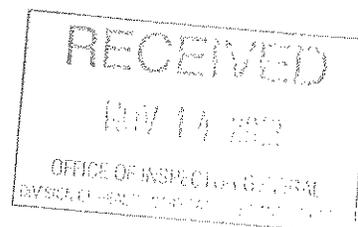


To ensure continued compliance, Housekeeping Director will monitor 28 rooms for a privacy curtain once a week beginning 11/14/12 utilizing the Privacy Curtain Audit Tool. Audits will occur each week for 4 weeks, monthly times 2 months and quarterly for 2 quarters to ensure compliance.

To ensure continued compliance, DCDs will monitor to ensure privacy is maintained during ADL care and treatment procedures 3 times per week utilizing a Nursing Services QAPI Tool beginning 11/14/2012. Each DCD will Audit 7 residents each week for 4 weeks, monthly times 2 months and quarterly for 2 quarters to ensure compliance.

To ensure continued compliance, meal monitors /Department Managers will monitor meal delivery 9 times per week to ensure compliance with dignity as it relates to sitting during meal times utilizing Dining Observation QAPI Tool beginning 11/14/2012. Audits will occur each week for 4 weeks, monthly times 2 months and quarterly for 2 quarters to ensure compliance. Areas of non-compliance will be addressed immediately.

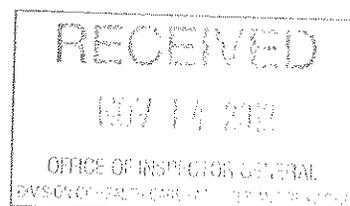
Audit results will be reviewed during



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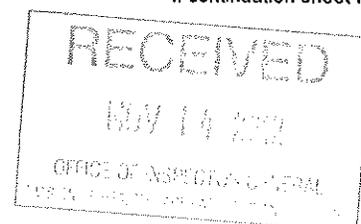
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F 241	Continued From page 7 preceptor. The DCD revealed that all facility supervisors were responsible to see that CNA's were trained on the proper ways to feed a resident. Interview with the DON, on 10/11/12 at 3:45 PM, revealed a CNA should have known not to stand when feeding a resident because they were taught proper feeding techniques during their training for CNA certification. The DON revealed she did not think the facility had any training in place for the proper feeding of residents because she had not had any issues concerning feeding residents. The DON was uncertain if the Dining Checklist the CNA's are given in new employee orientation mentioned whether staff was to sit or stand when feeding a resident.	F 241	our QAA process. The quality assessment and assurance (QAA) committee (Administrator, Assistant Administrator, ADNS, Medical Director, DCDs, Social Services, Maintenance) will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012. 11/19/2012 F252		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide a clean and odor free environment for one (1) of five (5) units for three (3) days on the Arcadia unit. One (1) of six (6) resident shower rooms was observed to have a caked black/brown substance on the grout line of the tiled wall and floor. In addition, soiled, odorous clothing were left exposed in resident	F 252	It is the practice of this facility to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Resident #3 still resides in the center. Resident #3 and roommate's soiled linen and soiled personal laundry will be bagged daily and taken to appropriate receptacle. Brown substance on tile wall and floor was cleaned by the Director of Housekeeping on 10/12/2012. How will you identify other residents		



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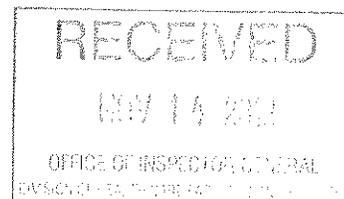
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F 252	<p>Continued From page 8 rooms allowing the odor to permeate the room and into the hall.</p> <p>The findings include:</p> <p>Record review of the undated facility policy Patient Room Cleaning revealed the policy did not include any scheduled times for cleaning of facility common areas. The policy titled Housekeeping Manual, Chapter 3 for Shower & Tub Cleaning, dated 03/01/03, revealed the facility was to establish the proper guidelines and procedures for cleaning all showers. This policy did not provide any times for when cleaning was to be performed. The undated policy titled Specialized Flooring, Chapter 4 for Ceramic Tile, revealed ceramic tile cleaning is a specialized procedure to maintain the tile and the beauty of the floor and to prevent slips and falls and this policy did not provide any times for when cleaning was to be performed. No policy was provided on odors. No policy was provided on handling soiled resident clothing.</p> <p>1. Observation, on 10/09/12 at 8:30 AM, during tour revealed a strong pervasive odor of musty/urine on the hallway into and past the double doors leading in the locked Arcadia unit. One housekeeper was observed with a cleaning cart going in and out of resident rooms as residents were getting up for breakfast.</p> <p>Observation, on 10/09/12 at 2:15 PM, in Resident #3's room revealed both residents had laundry baskets lined with plastic bags, no lids and open to air. Resident #3's roommate laundry basket contained wet clothing with a strong smell of concentrated urine that permeated the room and</p>	F 252	<p>having the potential to be affected by the same deficient practice? – Current residents have the potential to be affected.</p> <p>A facility wide audit will be conducted by the Housekeeping Director on or before 11/18/2012 of resident rooms to ensure personal clothing and linen laundered by family is bagged and placed in appropriate receptacle with a lid. Residents having clothes laundered by facility will have linen hamper removed from their room.</p> <p>An audit of other shower rooms will be completed by the Housekeeping Director and provided with deep cleaning if indicated on or before 11/18/2012.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? – To ensure deficient practice does not recur, facility staff will be educated on change in system for storing soiled linen by Administrator, Assistant Administrator, HR, Nurse Supervisor or Director of Housekeeping on or before 11/18/2012. Those changes include: personal clothing and linen laundered by family is bagged and</p>		



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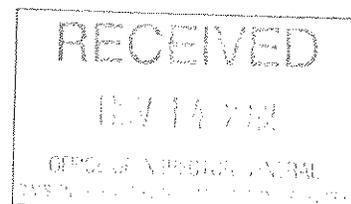
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F 252	<p>Continued From page 9 out into the hall way.</p> <p>Observation, on 10/09/12 at 5:00 PM, on the locked Arcadia unit revealed the same pervasive odor of musty/urine on the hallway.</p> <p>Observation, on 10/10/12 at 8:30 AM, of Resident #3's room revealed both laundry bin were open to air and the resident in bed 1's laundry bin had not been emptied of the soiled clothing and the strong smell of urine remained.</p> <p>Observation, on 10/10/12 at 11:00 AM, revealed the same strong pervasive odor of musty/urine on the hallway into and past the double doors leading in to the locked Arcadia unit.</p> <p>Observation, on 10/11/12 at 3:15 PM, during the environmental tour revealed a pervasive odor of musty/urine on the hallway into and past the double doors leading in the locked Arcadia unit.</p> <p>Interview, on 10/11/12 at 3:15 PM, with Certified Nursing Assistant (CNA) #7 revealed she thought the reason for the odor on the Arcadia Unit was from the carpet in the hallway. She further revealed residents' laundry baskets should have lids to prevent odors.</p> <p>Interview, on 10/11/12 at 3:20 PM, with Director of Environmental Services during the environment tour revealed that both the laundry baskets in Resident #3's semi-private room did not have lids. He further stated the laundry basket contained dirty clothes and smelled of urine. The director revealed that the soiled resident clothing should have been bagged up and taken to the laundry.</p>	F 252	<p>placed in appropriate receptacle with a lid. Residents having clothes laundered by facility will have linen hamper removed from their room.</p> <p>To ensure the deficient practice does not recur, a Shower Room Cleaning Assignment sheet has been implemented to be utilized by housekeeping staff for a daily cleaning of shower rooms beginning 11/1/2012 by the Housekeeping Director. Facility staff were educated on the requirement to have a proper fitting lid on dirty clothes receptacles for personal linen that is laundered by family by Administrator, Assistant Administrator, HR Director, Nurse Supervisor or Housekeeping Director by 11/18/2012. Facility staff will also be educated on bagging personal clothing and linen for residents where facility does laundry during this same inservice.</p> <p>Housekeeping Director educated housekeeping staff on the Shower Room Cleaning Assignment sheet on 10/31/12.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained – An audit of 10 rooms for linen done by families and linen done at the center as well as</p>		



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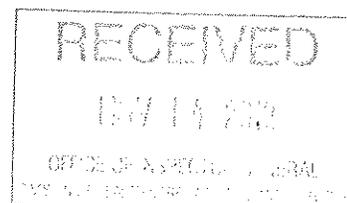
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F 252	<p>Continued From page 10</p> <p>Interview, on 10/11/12 at 3:30 PM, with the Charge Nurse of the Arcadia Unit, Registered Nurse (RN) #2 revealed the laundry baskets in Resident #3's semi-private room had no lids and was open to air. RN #2 revealed the laundry basket for bed one contained dirty clothes with the smell of urine coming from the basket without a lid and they should have been bagged up for the laundry or for the family to take home and wash. She further stated staff have been trained to handle soiled clothes and linen but was not able to provide the date and time of those training's. She further stated it was possible un-bagged soiled resident clothes could effect the smell of the unit which was not pleasant. RN #2 revealed she was aware of the smell on the unit.</p> <p>Interview, on 10/11/12 at 3:40 PM, with the Director of Nursing (DON) revealed the carpet was a concern on the Arcadia unit because so many of the resident are incontinent of bowel and bladder which can contribute to the smell of urine. The DON stated the smell of urine was not a pleasant environment for the residents.</p> <p>Interview, on 10/11/12 at 4:45 PM, with the Administrator revealed facility odors were not something they wanted at their facility.</p> <p>2. Observation, on 10/10/12 at 10:45 AM, revealed the 100 unit shower room stall had a caked brown/black substance on the grout line of the tiled wall and floor.</p> <p>Interview, on 10/10/12 at 10:50 AM, with Housekeeper #1 outside the 100 unit resident shower room, revealed she had just cleaned the</p>	F 252	<p>monitoring for odors will be conducted by the Housekeeping Director and Assistant Administrator to ensure environmental odors are contained utilizing the Linen Audit Tool beginning 11/14/2012.</p> <p>Areas of non-compliance will be corrected immediately upon discovery by Housekeeping Staff and Nursing Department. These audits will be completed 2 times per week for 4 weeks, monthly times 2 months and quarterly for 2 quarters. Areas of non-compliance will be corrected immediately.</p> <p>Housekeeping Director and Assistant Administrator will conduct audits of shower rooms 2 times a week utilizing environmental/housekeeping QAPI tool to ensure compliance beginning 11/14/2012. Areas of non-compliance will be corrected immediately upon discovery by Housekeeping Staff and Nursing Department.</p> <p>These audits will be completed 2 times per week for 4 weeks, monthly times 2 months and quarterly for 2 quarters. Areas of non-compliance will address immediately.</p> <p>Audit results will be reviewed during</p>	



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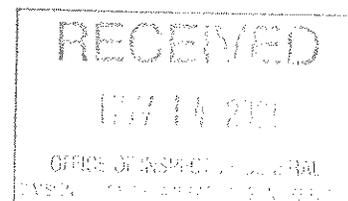
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F 252	Continued From page 11 shower room. She further stated cleaning the shower room included cleaning the toilet, the ceramic floor and the shower stall tile were to be deep cleaned every week. She stated she did not deep clean this shower, nor had the 100 unit shower room been deep cleaned for two (2) weeks. Observation, on 10/10/12 at 11:05 AM, revealed the 100 unit shower stall did not look any different after being cleaned than the first observation made at 10:45 AM. Observation, on 10/11/12 at 2:30 PM, revealed the 100 unit shower stall had a brown/black substance on the grout line of the tiled wall and floor as was found on 10/10/12. Interview, on 10/11/12 at 2:30 PM, with the Director of Environmental Services revealed he had cleaned the shower stall on the 100 unit as it was in need of cleaning. He further revealed the facility policy was to deep clean the resident shower rooms every week and the facility provides a steam cleaner to complete those cleaning task. The Director of Environmental Services stated he did not utilize or maintain any audit or check list sheets for the facility shower rooms when cleaned. Interview, on 10/11/12 at 4:45 PM, with the Administrator revealed all facility staff are trained in orientation on policy and procedures and it was his responsibility to ensure the facility was clean.	F 252	our QAA process. The quality assessment and assurance (QAA) committee (Administrator, Assistant Administrator, ADNS, Medical Director, DCDs, Social Services, Maintenance) will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012. 11/19/2012	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279	F279 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive	



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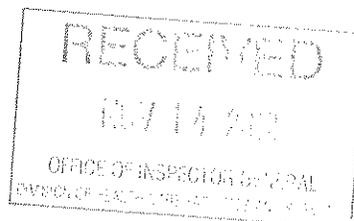
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F 279	<p>Continued From page 12 to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to develop comprehensive care plans for residents on psychotropic medications to include non-pharmacological interventions for two (2) of twenty-four (24) sampled residents and twelve (12) unsampled residents (Residents #4, #10).</p> <p>The findings include: Review of the facility's policy, Psychotropic Medications-Mood and Behavior Care Plans, dated 03/2011, revealed comprehensive care plans were developed based upon assessments of the resident and focused on all the resident's</p>	F 279	<p>plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Resident #4 and resident #10 clinical record has been reviewed and the clinical record revised for resident #4 to reflect management of residents anti-anxiety medication and updated to reflect changes as indicated by Directors of Care Delivery on or before 11/9/2012.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice? – ADNS, DCDs or Nurse Supervisor will complete an audit of like residents who receive anti-anxiety medication and update clinical record to include non-pharmacological interventions on or before 11/9/2012.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient</p>	



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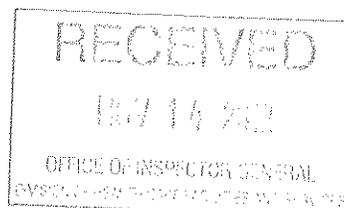
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F 279	<p>Continued From page 13</p> <p>issues including those associated with behavior or mood symptoms. Non-pharmacologic interventions can minimize the need for medications and permit the medication to be decreased or discontinued. The interventions were to be individualized for the resident based on the resident's preferences and daily customary routines.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Multiple Injuries from a MVA in 2011. The facility readmitted the resident on 06/13/12 and completed an admission Minimum Data Set (MDS) assessment on 06/20/12 which indicated the resident had a BIMS of fifteen (15) and the resident required extensive assistance of staff for dressing and limited assistance with hygiene.</p> <p>Review of the comprehensive care plan, dated 06/20/12, for Resident #4, revealed the facility identified the resident had anxiety issues related to a change in routine/caregiver and loss of control. This problem was addressed and last updated on 06/20/12. The interventions were to provide the resident with medication, evaluate the resident for side effects and to offer choices.</p> <p>Interview with Resident #4, on 10/09/12 at 1:30 PM, revealed the resident experienced anxiety and nervousness, especially in the evenings. He stated he asked for his medication and was provided with the medication. The resident indicated the facility had never discussed a daily routine, anxiousness, or ways to assist the resident in feeling more in control.</p>	F 279	<p>practice does not recur? – ADNS, DCDs or Nurse Supervisor will re-inservice Social Workers, MDS Coordinator, Activities Director, Dieticians and Licensed Nurses on completing and revising care plans based on a comprehensive assessment to include the implementation and documentation of non-pharmacological interventions on or before 11/18/12.</p> <p>To ensure the deficient practice does not recur, the interdisciplinary team consisting of the Administrator, ADNS, DCDs and Social Workers, will monitor non-pharmacological interventions through the Eagle Room process daily beginning 11/14/2012. Staff identified to be non-compliant with process will be educated and/or disciplined by the DCDs. Areas of non-compliance will be corrected immediately by the IDT.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained -? Residents admitted on anti-anxiety medications or receiving new orders for anti-anxiety medications will have their care plan audited upon admission or when the new order is received and reviewed daily in Eagle Room by DCDs for 4 weeks, monthly times 2</p>		



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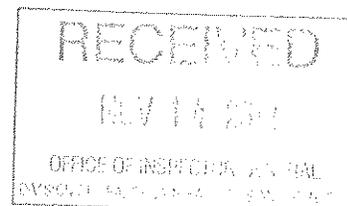
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F 279	<p>Continued From page 14</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 10/11/12 at 2:45 PM, revealed Resident #4 would request psychotropic medication, when feeling anxious, and received the medication. She stated she was not aware of any non-medication interventions being tried to relieve the resident's anxiety and the care plan had no information regarding non-medication interventions.</p> <p>Review of the clinical record for Resident #10, revealed the facility admitted the resident on 08/01/12, with diagnoses of Congestive Heart Failure and Chronic Kidney Disease. The facility completed an admission MDS on 08/14/12 which revealed a BIMS of fifteen (15). The resident required extensive assistance of staff for hygiene and limited assistance for dressing. The physician ordered an as needed psychotropic for anxiety on 09/28/12.</p> <p>Review of the comprehensive care plan, dated 09/28/12, for Resident #10, revealed the facility developed a care plan for agitation and anxiety due to lack of control. The care plan addressed administering the medication and monitoring for side effects and effectiveness; however, the care plan did not include any non-medication interventions to assist the resident in decreasing the anxiety.</p> <p>Interview with Resident #10, on 10/11/12 at 9:00 AM, revealed the facility had not discussed a plan to assist the resident with anxiety using non-pharmacologic interventions.</p> <p>Interview with Registered Nurse (RN) #2, on 10/11/12 at 11:00 AM, revealed she was unable</p>	F 279	<p>months and quarterly for 2 quarters utilizing the Psychoactive QAPI tool beginning 11/14/2012. Areas of non-compliance will be corrected immediately by the DCDs. Education on this process will be reviewed in orientation for new nurses.</p> <p>Audit results will be reviewed during our QAA process. The quality assessment and assurance (QAA) committee (Administrator, Assistant Administrator, ADNS, Medical Director, DCDs, Social Services, Maintenance) will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012.</p> <p>11/19/2012</p>		



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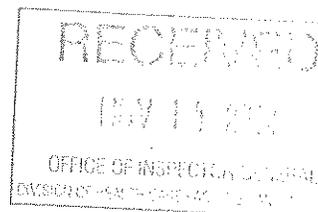
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F 279	Continued From page 15 to provide any documentation indicating Residents #4 and #10 had care plan interventions of a non-pharmacologic manner to reduce anxiety or agitation. She stated the residents complain of anxiety and nursing provides them with the drug ordered by the physician. She stated she was not trained on non-pharmacologic interventions and the care plans for both residents did not provide her with information. Interview with the Director of Nursing, on 10/11/12 at 3:45 PM, revealed staff had not received training on using non-pharmacologic interventions for residents on psychotropic medications. She stated she was not sure about what interventions may have been attempted prior to the medications being implemented or if they were successful.	F 279			
F 309 SS=E	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 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to follow physician orders to prevent medication errors for two (2) of twenty-four (24) sampled residents and one (1) of twelve (12)	F 309	F309 It is the practice of this facility to ensure each resident received and be provided with 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Res #15 no longer resides in the center.		



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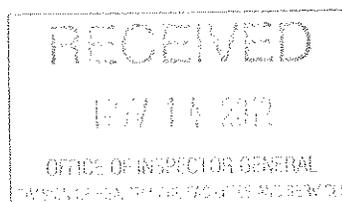
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2012
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	
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F 309	<p>Continued From page 16 unsampled residents. Resident #10, #15 and unsampled Resident #L.</p> <p>The findings include:</p> <p>Review of the facility's Medication Management Guidelines: Errors, dated 08/11/06, revealed an "error" means any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication was in the control of the health care professional, patient, or consumer.</p> <p>1. Observation of Licensed Practical Nurse (LPN) #4 performing a Medication Pass with Resident #10, on 10/10/12 at 8:30 AM, revealed the nurse pulling multiple medications without glancing at the Medication Administration Record (MAR). LPN #4 counted out fifteen (15) medications and administered the medications which included Diltiazem ER 360 mg to Resident #10.</p> <p>Record review of the Resident #10's MAR, dated 10/12, revealed the medication Diltiazem ER was not present on the MAR.</p> <p>Interview with LPN #4, on 10/10/12 at 5:21 PM, revealed she knew Resident #10 was to receive the Diltiazem ER because she gave Resident #10 the medication last month. LPN #4 stated you get into a routine of pulling a medication and made a mistake for not checking the MAR. LPN #4 stated she was checking the MAR but not close enough. LPN #4 stated she did not normally just pull medications and not look at the MAR. LPN #4 stated Diltiazem ER was a heart medication and if administered in error could cause some heart complications.</p>	F 309	<p>Res #10 was assessed by DCD on 10/11/2012 and suffered no ill effects as a result from receiving physician ordered medications.</p> <p>Resident L no longer resides in the center.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice? – Current residents and new admissions have the potential to be affected.</p> <p>The DCDs or Nurse Supervisor reviewed current resident medications to ensure physician orders were followed on or before 11/18/12. Any areas on non-compliance found were corrected by the DCDs or Nurse Supervisor to include notification to the attending physician and resident and/or responsible party.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? – Current Licensed Nurses administering medications to residents were re-inserviced on medication administration standards of practice by the ADNS, DCDs or Nurse Supervisor on or before 11/18/12. Current RNs</p>	



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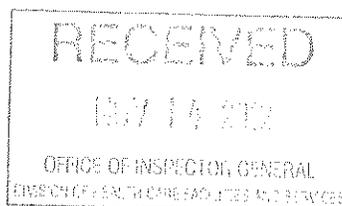
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F 309	Continued From page 17 Interview with the Director of Clinical Delivery (DCD) #3, on 10/10/12 at 10:40 AM, revealed nurses were to check the MAR every time when giving medications. The DCD #3 stated Resident #10's blood pressure could drop if he/she was not supposed to receive the medication. 2. Observation of LPN #6 performing a medication pass on Resident #15, on 10/10/11 at 9:00 AM, revealed the nurse pulling nine (9) medications and administering them as ordered to Resident #15. Record review of Resident #15's MAR, dated 10/12, revealed LPN #6 failed to administer Folic Acid 1 mg (Vitamin), Lasix 20 mg. (medication for water retention and blood pressure) and Kepra 500 mg. (medication to prevent seizures). Record review of Resident #15's physician orders, dated 09/26/12, revealed an order for Senokot (constipation relief) two (2) tabs by mouth every day was ordered. Record review of the MAR revealed Senokot was not present on the MAR and was not given by LPN #6. A total of four medications were ordered for Resident #15 but were not given to Resident #15 during the medication pass observation. Interview with LPN #6, on 10/10/12 at 9:22 AM, revealed she was not aware she had missed any medications. Interview with the DCD #4, on 10/10/12 at 10:05 AM, revealed she was responsible for the nurses on the unit. The DCD #4 stated the missed	F 309	and LPNs will conduct medication administration skill validation observed by the ADNS, DCDs, Nurse Supervisor or clinical services consultants on or before 11/18/12. Those licensed nurses unable to successfully complete a medication administration skill validation will be re-inserviced by the ADNS, DCDs or Nurse Supervisor and an additional medication administration skills validation will be completed until licensed nurse is able to demonstrate medication administration without error. To ensure the deficient practice does not recur, licensed nurses with annual review and new orientees during orientation will be educated on the Standards of Practice for medication administration as well as have a Medication Administration Skills Validation completed by the ADNS, DCDs or Nurse Supervisor. Areas of non-compliance will be re-inserviced by the ADNS, DCDs or Nurse Supervisor and additional medication administration skill validations will be completed until licensed nurse is able to demonstrate medication administration without error. How does the facility plan to monitor its performance to ensure that	



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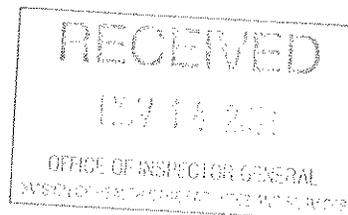
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F 309	<p>Continued From page 18</p> <p>dosage administration of Kepra could affect the level of Kepra in the system and cause the resident to have seizures. When the DCD #4 was asked how she ensured the nursing staff were performing their duties correctly, the DCD stated she had not completed any random checks on medication pass.</p> <p>Record review of LPN #6's employee file revealed LPN #6 worked as a Certified Nursing Assistant in the facility and had just received her LPN license within a six (6) month period. While in orientation of the facility working as an LPN, LPN #6 did not receive an examination on medication pass, but received a floor orientation.</p> <p>Interview with the Director of Nursing, on 10/11/12 at 1:27 PM, revealed upon hire the nursing staff were given a medication examination before administering medication. Since LPN #6 was already an employee in the facility, LPN #6 only received the floor training and did not go through the class training.</p> <p>Interview with Physician #1, on 10/11/12 at 4:20 PM, revealed Resident #15 had sustained a head injury prior to coming to the facility and Resident #15 was taking Kepra as a prophylactic. Physician #1 also stated Resident #15 had never sustained any seizures, but because the injury was so severe to the brain, Resident #15 was given the medication as a preventive medication.</p> <p>3. Observation of LPN #5, on 10/11/12 at 7:40 AM, revealed the nurse pulled eleven (11) medications, crushed ten (10) medications (including Bupropion SR 200 mg. [sustained release medication which helps with the</p>	F 309	<p>solutions are sustained – To ensure continued compliance, the ADNS, DCDs or Nurse Supervisor will conduct medication administration skills validation of 1 nurse per shift utilizing the Medication Administration QAPI tool two times per week for four for 4 weeks, monthly times 2 months and quarterly for 2 quarters to ensure medications are given per physician order beginning 11/14/2012 Licensed nurses unable to successfully complete the Medication Administration Skills Validation will be inserviced by the ADNS, DCDs or Nurse Supervisor and an additional Medication Skills Validation will be completed until licensed nurse is able to demonstrate medication administration without error. Licensed Nurse will be supervised by DCD or Nurse Supervisor to ensure accuracy of medication pass. Areas of non-compliance will be corrected immediately.</p> <p>Audit results will be reviewed during our QAA process. The quality assessment and assurance (QAA) committee (Administrator, Assistant Administrator, ADNS, Medical Director, DCDs, Social Services, Maintenance) will validate the actions taken are effectively</p>	



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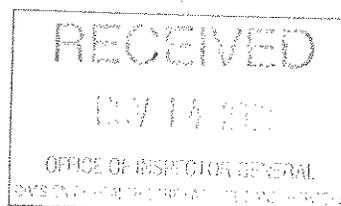
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F 309	<p>Continued From page 19 treatment of depression]) and placed the crushed medications in applesauce. LPN #5 administered the medications in applesauce to unsampled Resident #L.</p> <p>Interview with LPN #5, on 10/11/12 at 8:51 AM, revealed she had crushed everything except for Neurontin (anticonvulsant) which was a capsule. LPN #5 stated the Bupropion SR was not to be crushed because of the way the medication released in the body. LPN #5 stated the medication could cause ill effects when crushed and absorbed too quickly, although, she did not know what those ill effects were.</p> <p>Interview with the DCD #4, on 10/10/12 at 10:05 AM, revealed SR meant sustained release because it released slowly in the body and the medication was not to be crushed because it could cause the resident to receive too much medication at one time. The DCD #4 stated she was concerned and would never want something to harm a resident.</p> <p>Interview with the Psychiatric Nurse Practitioner, on 10/11/12 at 12:15 PM, revealed Bupropion SR was not to be crushed because it was a sustained release capsule. If the medication was crushed and given it could cause increased anxiety and heart rate. The Psychiatric Nurse Practitioner stated she would ask the nurse to monitor Resident #L, who received the crushed Bupropion SR, for increased anxiety and heart rate and did not feel this medication error was something that needed to be addressed at the hospital.</p> <p>Interview with Physician #1, on 10/11/12 at 4:20</p>	F 309	<p>resolving the cited issues beginning 11/15/2012.</p> <p>11/19/2012.</p>	



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F 309	Continued From page 20 PM, revealed he was concerned with the large number of medication errors. Physician #1 stated all of the medication errors were of significant concern, however, there were no negative outcomes to the residents. Interview with the DON, on 10/11/12 at 1:27 PM, revealed she took the medication errors seriously. However, she could not tell how she felt about the errors until she completed some investigating of her own. The DON could not expound on if she felt the medication errors were significant or not without further investigation.	F 309		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure a medication error rate of 5% or less was achieved. The medication pass observation revealed an error rate of 12 % for six (6) errors of forty-seven (47) opportunities. The findings include: Review of the facility's Medication Management Guidelines: Errors, dated 08/11/06, revealed an "error" means any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication was in the control of the health care professional, patient or	F 332	F332 It is the practice of this facility to ensure it is free of medication error rates of 5 percent or greater. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice –The Statement of Deficiencies does not identify any specific targeted residents. How will you identify other residents having the potential to be affected by the same deficient practice? Current residents and new admissions have the potential to be affected. The DCDs or Nurse Supervisor reviewed current resident medications	



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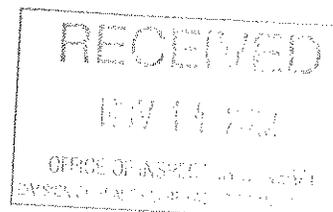
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F 332	<p>Continued From page 21 consumer.</p> <p>Observations, on 10/10/12 and 10/11/12, of the medication pass with three nurses revealed a total of forty-seven (47) medications were given to random residents observed. Of the forty-seven (47) total medications observed, six (6) of the forty-seven (47) medications were administered in error, not transcribed onto the MAR or totally missed by the nursing staff. These six medications errors caused a 12% medication error rate.</p> <p>Interview with Director of Clinical Delivery (DCD) #4, on 10/10/12 at 10:40 AM, revealed she could not remember if any medication errors had occurred in the past year. The DCD stated when the nurses were up for evaluation, the nurses were evaluated on medication pass at that time. The DCD further stated she was responsible for the nurses who provided care and if there were any concerns with the med pass she would address the nurse at that time, though she did not do frequent monitoring of the medication pass.</p> <p>Interview with the Director of Nursing (DON), on 10/11/12 at 1:27 PM, revealed she thought the medication error rate was high. The DON stated Pharmacy Services had completed random medication passes, as well, there were random medication audits. If a nurse was found to make a medication error the nurse was to watch a video and complete a post video test. The DON stated during a mock medication pass there were some medication errors identified, but could not determine what those errors were without looking at what the findings were. The DON stated she was responsible for the nursing staff and felt the</p>	F 332	<p>to ensure physician orders were followed on or before 11/18/12. Any areas on non-compliance found were corrected by the DCDs or Nurse Supervisor to include notification to the attending physician and resident and/or responsible party.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Current Licensed Nurses administering medications to residents were re-inserviced on medication administration standards of practice by the ADNS, DCDs or Nurse Supervisor on or before 11/18/12. Current RNs and LPNs will conduct medication administration skills validation observed by the ADNS, DCDs, Nurse Supervisor or clinical services consultants on or before 11/18/12. Those licensed nurses unable to successfully complete a medication administration skills validation will be re-inserviced by the ADNS, DCDs or Nurse Supervisor and an additional medication administration skills validation will be completed until licensed nurse is able to demonstrate medication administration without error.</p>		

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To ensure the deficient practice does not recur, licensed nurses with annual review and new orientees during orientation will be educated on the Standards of Practice for medication administration as well as have a Medication Administration Skills Validation completed by the ADNS, DCDs or Nurse Supervisor. Areas of non-compliance will be re-inserviced by the ADNS, DCDs or Nurse Supervisor and additional medication administration skills validations will be completed until licensed nurse is able to demonstrate medication administration without error.

How does the facility plan to monitor its performance to ensure that solutions are sustained --?To ensure continued compliance, the ADNS, DCDs or Nurse Supervisor will conduct medication administration skills validation of 1 nurse per shift utilizing the Medication Administration QAPI tool two times per week for four for 4 weeks, monthly times 2 months and quarterly for 2 quarters to ensure medications are given per physician order beginning 11/14/2012 Licensed nurses unable to successfully complete the Medication Administration Skills Validation will be inserviced by the ADNS, DCDs or Nurse Supervisor and



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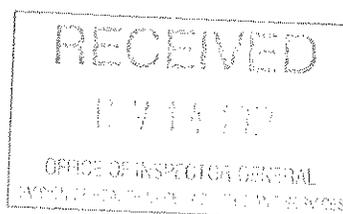
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F 332	Continued From page 22 system she had in place was still effective for prevention of medication errors.	F 332	an additional Medication Skills Validation will be completed until licensed nurse is able to demonstrate medication administration without error. Licensed Nurse will be supervised by DCD or Nurse Supervisor to ensure accuracy of medication pass. Areas of non-compliance will be corrected immediately.	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy, it was determined the facility failed to offer a snack to sixty-seven (67) residents, of the 149 census, with physician orders for a bedtime snack. The findings include:	F 368	Audit results will be reviewed during our QAA process. The quality assessment and assurance (QAA) committee (Administrator, Assistant Administrator, ADNS, Medical Director, DCDs, Social Services, Maintenance) will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012. 11/19/2012. F368 It is the practice of this facility to ensure each resident receives and is provided at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and	



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F 368	<p>Continued From page 23</p> <p>Review of the facility policy on meals, undated, revealed all residents would be offered bedtime snacks.</p> <p>Interviews with Residents #11, #19, and Unsampled Resident A and B during the Group Interview, on 10/10/12 at 10:30 AM, revealed the facility did not offer all residents bedtime snacks, and at times, residents with orders for snacks did not receive them. They stated they were not offered a bedtime snack.</p> <p>Review of the snack list printed by the facility on 10/11/12 revealed a total of sixty-seven (67) residents listed with a physician ordered snack. Resident #11 and Unsampled Resident B were on the list. Resident #19 and Unsampled Resident A were not on the list.</p> <p>Interview with Certified Nurse Aide #4, on 10/11/12 at 2:05 PM, revealed all residents were not offered a snack. She stated the facility had not trained her to offer a snack to all residents.</p> <p>Interview with CNA #5, on 10/11/12 at 2:30 PM, revealed residents not offered snacks could ask for a snack if desired. She stated the facility had snacks locked in a refrigerator on the 100 unit. She indicated the supervisor could be called and she could go to 100 and get a snack and bring it to the resident. She stated residents were told on admission that they could have a bedtime snack if they requested one.</p> <p>Interview with Registered Nurse #4, on 10/11/12 at 2:40 PM, revealed the facility sent out snacks from the kitchen in the evenings and the snacks were passed out according to the attached labels</p>	F 368	<p>breakfast the following day, except as provided in (4) below. (3) The facility must offer snacks at bedtime daily. (4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Resident #19 no longer resides in the center.</p> <p>Meeting was held with Resident #11, A and B on 11/9/2012 by the Dieticians to review the HS snack program.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice? – Current residents and new admissions receiving an oral diet have the potential to be affected.</p> <p>Nursing staff will be educated by DCDs, Dieticians or Nurse Supervisor on offering HS snacks to appropriate residents on or before 11/18/2012</p> <p>Residents will be educated by the Administrator, Assistant Administrator</p>	



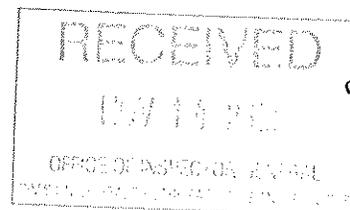
and Dieticians on the HS snack program on or before 11/18/2012.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? –

HS snacks will be stocked at the nurses' station by dietary staff daily for nursing staff to access and provide to residents as appropriate beginning 11/14/2012. One Certified Nursing Assistant (CNA) will be assigned to offer HS snacks daily. The assigned CNA will record HS snack in the electronic medical record noting if HS snack was accepted or refused. The licensed nurses will validate completion of the delivery of snacks and completion of documentation prior to the end of the CNA's shift.

Nurse Supervisor will conduct 10 interviews of residents regarding an HS snack being offered to ensure overall compliance utilizing the QAA HS Snack Audit tool beginning 11/14/2012.

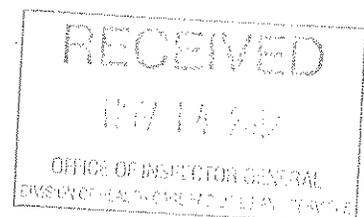
How does the facility plan to monitor its performance to ensure that solutions are sustained – Nurse Supervisor will conduct 10 interviews of residents regarding an HS snack



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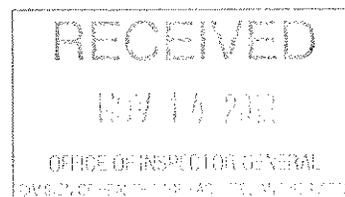
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F 368 F 465 SS=D	Continued From page 24 for specific residents. She stated snacks were not offered to all residents. 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide a safe, functional and sanitary environment for one (1) of six (6) facility shower rooms. Broken and missing tiles from the shower wall and floor were observed at the entrance into the shower stall of the 100 unit shower room. The findings include: Record review of the facility's documentation provided as a policy titled Direct Supply TELS user guide, undated, revealed a work schedule computer program instructing the user to Print a Work Schedule. Tasks are documented as weekly or monthly and the program automatically provides logbook forms to fill out. The program is designed to address regulatory guidance, logbook documentation, loss prevention, and disaster and emergency preparedness. The monthly task included inspection of Resident Bathing. The facility did not provide a policy on preventive maintenance for the facility shower rooms.	F 368 F 465	being offered to ensure overall compliance utilizing the QAA HS Snack Audit tool beginning 11/14/2012. QAA HS Snack audit will occur 2 times per week for 4 weeks, monthly times 2 months and quarterly for 2 quarters to ensure HS snacks are being offered. Areas of non-compliance will be corrected immediately. Audit results will be reviewed during our QAA process. The quality assessment and assurance (QAA) committee (Administrator, Assistant Administrator, ADNS, Medical Director, DCDs, Social Services, Maintenance) will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012. 11/19/2012 F465 The facility must provide a safe functional, sanitary, and comfortable environment for residents, staff and the public. What corrective action(s) will be accomplished for those residents	



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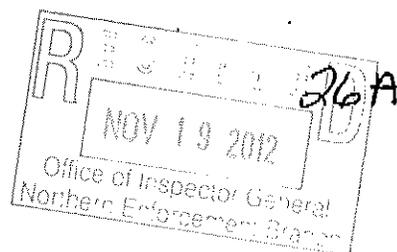
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2012
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220		
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F 465	<p>Continued From page 25</p> <p>Observation, on 10/11/12 at 10:46 AM, revealed on the 100 unit the resident shower room stall was found to have a row of floor tiles chipped, and one tile was cracked with missing pieces which created a small hole. Inside the hole, as a result of the missing piece of tile, was filled with a black/brown substance. In addition the wall that separated the shower stall from the toilet had two rows of 4 x 4 tiles surrounded by a plastic corner bumper; however, the surface of the 4 x 4 tiles were pushed in, cracked and missing from that wall.</p> <p>Interview, on 10/11/12 at 2:30 PM, with Director of Environmental Services revealed he was aware of the shower room stall which had broken, cracked, chipped, and missing tile on the floor and the wall between the shower stall and the toilet. He further stated a work order had been created for repairs.</p> <p>Interview, on 10/11/12 at 3:00 PM, with the Director of Maintenance during the environmental tour revealed he had not received any work orders for broken tile for the 100 unit shower room nor was he aware of any broken tile from his monthly and weekly rounds. He further stated the tiles were old and needed to be replaced. The Director of Maintenance acknowledged the possible risk which included resident skin injury.</p> <p>Interview, on 10/11/12 at 4:45 PM, with The Administrator revealed the facility shower rooms should not have broken and chipped tiles and should be repaired based on facility staff observation and daily rounds by the maintenance staff. He further stated it was his responsibility to ensure the facility was maintained.</p>	F 465	<p>found to have been affected by the deficient practice – The shower room on the 100 hall with the chipped/cracked tile will be repaired by the Maintenance Director or Maintenance Assistant by 11/18/2012.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice? – Current residents and new admissions using shower rooms have the potential to be affected.</p> <p>Shower rooms were inspected for chipped/cracked tile and a work order completed by the Maintenance Director and Maintenance Assistant on 11/2/2012. Areas identified will be corrected by 11/18/2012.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? – Housekeeping Director educated housekeeping staff on the Shower Room Cleaning Assignment Sheet on 10/31/12.</p> <p>To ensure the deficient practice does not recur, a Shower Room Cleaning Assignment sheet has been implemented to be utilized by</p>		



housekeeping staff for a daily cleaning of shower rooms beginning 11/1/2012 by the Housekeeping Director. Housekeeping will identify broken, cracked or missing tile and complete a maintenance work order for identified areas. Work orders will be reviewed by the Administrator or Assistant Administrator weekly to ensure the required repairs are completed. Those shower rooms with identified broken, cracked or missing tiles will be placed out of service until repairs can be made as quickly as possible.

How does the facility plan to monitor its performance to ensure that solutions are sustained –Assistant Administrator or Maintenance Director will audit shower rooms once a week for 4 weeks, monthly times 2 months and quarterly for 2 quarters to ensure showers have no broken, cracked or missing tile beginning 11/14/2012. Areas of non-compliance will be corrected immediately

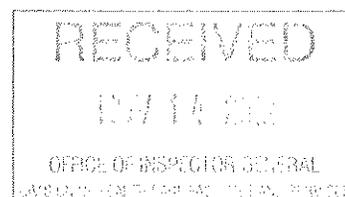
Audit results will be reviewed during our QAA process. The quality assessment and assurance (QAA) committee (Administrator, Assistant Administrator, ADNS, Medical Director, DCDs, Social Services, Maintenance) will validate



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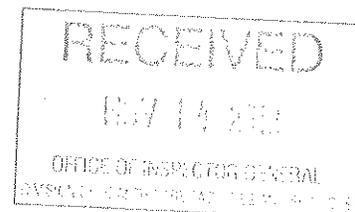
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F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain clinical records for transcription of physician orders on the MAR for two (2) of twenty-four (24) sampled residents and twelve (12) unsampled residents. Resident #10 and #15.</p> <p>The findings include:</p> <p>1. Record review of Resident #10's Discharge Reconciliation Orders, dated 09/25/12, revealed Res #10 was to continue to take Diltiazem ER 360 mg daily. Record review of Resident #10's Medication Administration Record (MAR) revealed the medication was not transcribed over to the October MAR.</p> <p>Observation of the medication pass, on 10/10/12</p>	F 514	<p>the actions taken are effectively resolving the cited issues beginning 11/15/2012.</p> <p>11/19/2012</p> <p>F514</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are - (i) Complete; (ii) Accurately documented; (iii) readily accessible; and (iv) Systematically organized.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Resident #15 no longer resides in the center. Resident #10 suffered no ill effects from omission of Diltiazem-Er-360mg as ordered by physician.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice? Current residents and new admissions receiving medications have the potential to be affected by the deficient practice.</p> <p>Current licensed nurses as well as</p>	



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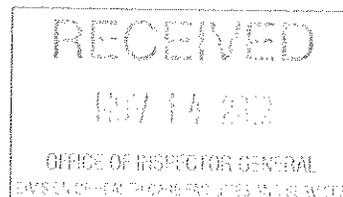
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F 514	<p>Continued From page 27</p> <p>at 8:30 AM, revealed Resident #10 was given Diltiazem ER 360 mg by Licensed Practical Nurse (LPN) #4.</p> <p>Interview with LPN #4, on 10/10/12 at 5:21 PM, revealed the medication was not transcribed over to the MAR from the September MAR. She new Resident #10 was to receive the Diltiazem ER because she gave Resident #10 the medication last month. LPN #4 stated she got into a routine of pulling a medication and made the mistake of not checking the MAR. LPN #4 was not aware the Diltiazem ER was not on the MAR. LPN #4 stated the admitting nurse was responsible to make sure all medications were transcribed onto the MAR as ordered. LPN #4 stated she new the night shift supervisors were checking MARs at night and she thought the unit managers double checked the MARs with the orders.</p> <p>Interview with Director of Clinical Delivery (DCD) #3, on 10/10/12 at 10:40 AM, revealed MAR's were printed off around the fifteenth (15 th) of every month. The night shift nursing staff was assigned to complete a certain number of MARs a day. Once the MARs were completed, on the last day of the month, a nurse would then double check the MAR's for accuracy. The DCD stated last month the facility implemented for the nursing Managers to triple check the MARs. DCD #3, further stated that she had conducted MAR checks for the month of October and missed the transcription error. DCD #3 further stated she was responsible for the care provided by the nursing staff on her unit.</p> <p>2. Record review of Resident #15's Physician Orders, dated 10/12, revealed Senokot two (2)</p>	F 514	<p>newly hired licensed nurses will be educated on transcription of orders and the end of month recap process by the DCDs or Nurse Supervisor on or before 11/18/2012.</p> <p>Clinical Services Consultants validated accuracy of the end of month recap process of physician orders from 10/29/2012 to 11/1/2012. Revisions of clinical records were made as indicated by the ADNS, DCDs and Nurse Supervisor immediately upon noted discrepancies.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Current licensed nurses as well as newly hired licensed nurses will be educated on transcription of orders and the end of month recap process by the DCDs or Nurse Supervisor on or before 11/18/2012.</p> <p>To ensure the deficient practice does not recur, the center will implement the Center Recap process which includes the simultaneous review of old and new orders for accurate transcription by 2 licensed nurses beginning with the October/November 2012 physician order recap.</p>		



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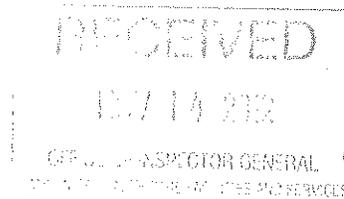
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F 514	<p>Continued From page 28</p> <p>tabs by mouth every day was ordered. Record review of the MAR for 10/12, revealed the order was not transposed on the MAR. Res #15 subsequently was not given Senokot for ten (10) days.</p> <p>Interview with LPN #6, on 10/10/11 at 9:22 AM, revealed she was not aware Resident #15's Senokot order was not transcribed over to the MAR.</p> <p>Interview with DCD #4, on 10/10/12 at 10:05 AM, revealed the night shift nurses checked the current physician orders and any new orders were transcribed onto the new MAR. The nurse then compared new MAR to old MAR to make sure all medications were transcribed over. This practice occurred monthly.</p> <p>Interview with the Director of Nursing (DON), on 10/11/12 at 1:27 PM, revealed she would expect the nursing staff to follow the physician orders because this was a part of nursing practice. The DON stated she was responsible for the nursing staff to make sure they were providing the appropriate care to the residents. The DON stated there were random medication audits and there was a fourth MAR check to prevent transcription errors. The nurses should be checking shift to shift and reporting any holes in the MARs. The DON further stated she felt secure in her process.</p>	F 514	<p>The Clinical Services Consultants will validate accuracy of the completion of the recap process beginning with the October/November 2012 physician order recap and continue for 2 months.</p> <p>The Clinical Services Consultants educated the ADNS, DCDs and Nurse Supervisor beginning with the October/November 2012 physician order recap on the validation process to ensure understanding and process for completion beginning with November/December 2012 physician order recap.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained – The Clinical Services Consultants will complete a Physician Order Recap Audit beginning 10/29/12 and then monthly x 2 months. The ADNS, DCDs and Nurse Supervisor will then complete the Physician Order Recap Audit monthly x 2 months and quarterly for 2 quarters to ensure the Physician Order Recap was completed accurately. Discrepancies found in the recap process will be correctly immediately by DCDs or Nurse Supervisor Areas of non-compliance will be corrected immediately.</p>	



Audit results will be reviewed during our QAA process. The quality assessment and assurance (QAA) committee (Administrator, Assistant Administrator, ADNS, Medical Director, DCDs, Social Services, Maintenance) will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012.

11/19/12



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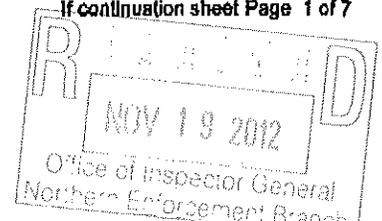
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1970 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF DP TYPE OF STRUCTURE: One (1) story, Type III (000) SMOKE COMPARTMENTS: Eleven (11) FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Automatic (dry) sprinkler system, hydraulically designed. GENERATOR: Type II generator installed in 2006. Fuel source is diesel. A standard Life Safety Code survey was conducted on 10/09/12. Christopher East Health Care Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has one-hundred and seventy-eight (178) certified beds and the census was one-hundred and forty-nine (149) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. K018 It is the practice of this facility to ensure that doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 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 doors. Doors are provided with a means suitable for keeping the door closed.	11/19/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Joseph Barrett TITLE: X Administrator (X5) DATE: X 11/19/12

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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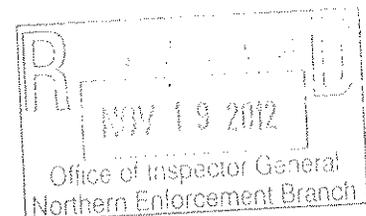
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K 000	Continued From page 1 Fire)	K 000	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Facility removed trash cans being used to hold identified doors in rooms 106, 112 and 120 open and adjusted doors to prevent self-closures on 10/17/12.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice –Current residents have the potential to be affected by this deficiency.</p> <p>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur – Doors in the facility were checked by Director of Maintenance and Maintenance Assistant to ensure doors were not propped open on 10/17/12. Administrator, Assistant Administrator, Human Resources Director or Nurse Supervisor will educate staff on or before 11/18/12 on NFFPA requirement to ensure doors are not blocked or impeded from closing.</p> <p>How the corrective action(s) will be monitored to ensure that solutions</p>		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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 19.3.6.3.5 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 observations and interviews, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, approximately forty-five (45) residents, staff and visitors. The</p>	K 018			



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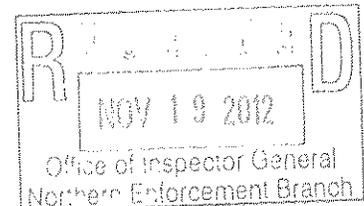
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K 018	Continued From page 2 facility has one-hundred and seventy-eight (178) certified beds and the census was one-hundred and forty-nine (149) on the day of the survey. The findings include: Observations, on 10/09/12 between 10:10 AM and 11:46 AM, with the Maintenance Director revealed trash cans were holding resident room doors 106, 112 and 120 open. When the trash cans were removed, the doors wanted to self-close. Interviews, on 10/09/12 between 10:10 AM and 11:45 AM, with the Maintenance Director revealed he was unaware the trash cans were being used to hold open the resident room doors and acknowledged the methods used were an impediment to closing the doors in the event of an emergency. Reference: NFPA 101 (2000 Edition) 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	are sustained —A door audit will be completed once a week for 4 weeks, monthly times 2 months and quarterly for 2 quarters by Maintenance Director or Maintenance Assistant. Maintenance Director or Maintenance or Assistant will report any issues from the audit results to the QAA committee until this issue is deemed resolved. Areas of non-compliance will be corrected immediately. The quality assessment and assurance (QAA) committee will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012. 11/19/2012 K029 It is the practice of this facility to	11/19/12	
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029			



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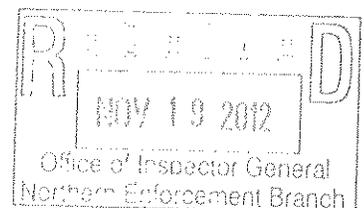
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NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220		
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K 029 SS-D	<p>Continued From page 3</p> <p>One hour 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</p> <p>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 eleven (11) smoke compartments, approximately thirty-five (35) residents, staff and visitors. The facility has one-hundred and seventy-eight (178) certified beds and the census was one-hundred and forty-nine (149) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/09/12 at 1:50 PM, with the Maintenance Director revealed the door to the Dry Storage Room in the Kitchen, did not have a self-closing device installed on the door.</p> <p>Interview, on 10/09/12 at 1:50 PM, with the</p>	K 029	<p>ensure that 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 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.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice - A self-closure was placed on the dry storage room in the kitchen on 10/17/12 by the Maintenance Director.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice - Current residents have the potential to be affected by this deficiency. All doors leading to hazardous storage areas were checked for a self-closing device by the Maintenance Director and Maintenance Assistant on 11/12/2012.</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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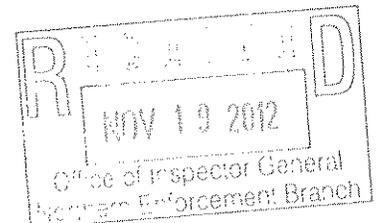
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2012
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220		
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K 029	Continued From page 4 Maintenance Director revealed he was not aware of the Dry Storage Room being categorized as a hazardous storage room, and the requirement that the door be equipped with a self-closing device. 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 (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	K 029	and these doors were equipped with a required self-closure. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur – Safety Committee (HR Director, 2 C.N.As, Staff Coordinator, 2 Housekeepers, Activity Director and Maintenance) will audit self-closure room doors weekly to validate self-closing doors to hazardous areas function properly. Safety Committee (HR Director, 2 C.N.As, Staff Coordinator, 2 Housekeepers, Activity Director and Maintenance) was inserviced by Assistant Administrator on doors requiring self-closure devices on 11/13/2012. How the corrective action(s) will be monitored to ensure that solutions are sustained – Safety Committee (HR Director, 2 C.N.As, Staff Coordinator, 2 Housekeepers, Activity Director and Maintenance) will conduct audits once a week for 4 weeks, monthly times 2 months and quarterly for 2 quarters and report audit findings to the Quality Assurance Committee for review until issue is deemed corrected. Areas of		



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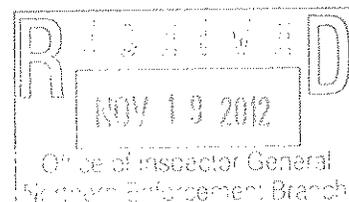
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K 029	Continued From page 5 those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	non-compliance will be corrected immediately. The quality assessment and assurance (QAA) committee will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012.		
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 two (2) of eleven (11) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has one-hundred and seventy-eight (178) certified beds and the census was one-hundred and forty-nine (149) on the day of the survey. The findings include: Observations, on 10/09/12 between 1:30 PM and 2:45 PM, with the Maintenance Director revealed: 1) In resident room 420, medical equipment (a suction device and a mini-nebulizer) were plugged into a power strip.	K 147	11/19/2012 K147 It is the practice of this facility to ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice - Medical equipment in rooms 420 and 310 were removed from power strip and plugged into proper electrical outlet on 10/09/12. The refrigerator and microwave in Director of Social Services' office were removed from power strip and plugged into proper electrical outlet on 10/10/12. How you will identify other	11/19/12	



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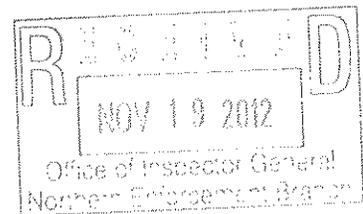
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K 147	<p>Continued From page 6</p> <p>2) In resident room 310, medical equipment (a motorized bed) was plugged into a power strip.</p> <p>3) In the Director of Social Services' office, a refrigerator and microwave oven were plugged into a power strip.</p> <p>Interviews, on 10/09/12 between 1:30 PM and 2:45 PM, with the Maintenance Director revealed he was not aware of the misuse of power strips within the facility.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>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.</p>	K 147	<p>residents having the potential to be affected by the same deficient practice – Offices and resident rooms in the center were inspected by Maintenance Director and Maintenance Assistant on 11/9/2012 and no other rooms were identified as having medical equipment plugged into a power strip. Current residents have the potential to be affected by this deficiency.</p> <p>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur – Residents, Responsible Party and staff will be educated by Administrator, Assistant Administrator, Nurse Supervisor and HR Director on the NFPA 70 National Electrical Code 9.1.2 by 11/18/2012. Safety Committee (HR Director, 2 C.N.As, Staff Coordinator, 2 Housekeepers, Activity Director and Maintenance) will audit 20 rooms per week to ensure the proper use of power strips in offices and resident rooms.</p> <p>How the corrective action(s) will be monitored to ensure that solutions are sustained – Room audits will be completed once a week for 4 weeks,</p>	



monthly times 2 months and quarterly for 2 quarters. Human Resources Director will monitor weekly audits to ensure safety rounds are completed and will report audit findings to the Quality Assurance Committee for review until issue is deemed corrected. Areas of non-compliance will be corrected immediately. The quality assessment and assurance (QAA) committee will validate the actions taken are effectively resolving the cited issues beginning 11/15/2012.

11/19/2012



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