



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

PRINTED: 11/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  10/30/2014
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF LANCASTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MAPLE AVENUE LANCASTER, KY 40444
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F 000	INITIAL COMMENTS	F 000	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by <i>Christian Care Center of Lancaster</i> of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. <i>Christian Care Center of Lancaster</i> files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to maintain a sterile field during tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube) care and suctioning and failed to ensure adequate oxygenation was provided during trach care for one (1) of nineteen (19) sampled residents (Resident #8).</p> <p>The findings include:  Review of the facility's policy titled "Tracheostomy Care for disposable Inner Cannulas and Non-Disposable Inner Cannulas," dated</p>		Christian Care Center of Lancaster believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *11/25/14*

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

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F 328	<p>Continued From page 1</p> <p>November 2008, revealed staff should don sterile gloves and maintain sterile technique throughout tracheostomy care.</p> <p>A review of the facility's policy titled "Suctioning," dated September 2013, revealed a sterile catheter container should be opened avoiding contamination.</p> <p>A review of the facility's reference material titled "Tracheostomy Care," dated February 2014, from Med-Pass Heaton Resources, revealed sterile gloves must be used for trach care. Further review of the facility's reference material titled "Suctioning the Lower Airway (Endotracheal or Tracheostomy Tube)," dated October 2010, from Med-Pass Heaton Resources, revealed sterile technique must include maintaining a sterile dominant hand for suctioning. Additionally, staff should monitor the resident's pulse and oxygen saturation during suctioning.</p> <p>An interview conducted with the Director of Nursing (DON) on 10/30/14 at 3:45 PM, revealed staff performing tracheal suctioning and trach care should maintain a sterile field. She stated contamination of the sterile field would include an increased risk of infection for the resident. In addition, the lack of oxygen during suctioning could potentially cause Hypoxia.</p> <p>A review of the Lippincott Manual of Nursing Practice 10th Edition, dated 2014, identified Hypoxia as insufficient oxygenation at the cellular level due to an imbalance in oxygen delivery and oxygen consumption.</p> <p>Record review revealed the facility admitted Resident #8 on 06/27/12 with diagnoses that</p>	F 328	<p><u>Corrective Actions for Targeted Residents</u></p> <p>Nurses assigned to care for Resident #8 on 10/30/14 through 11/4/14, to include LPN #1, were educated on setting up a sterile field, maintaining a sterile field, donning sterile gloves, and guidelines for maintaining oxygenation and re-oxygenation while endotracheal suctioning by the Director of Nursing. This education occurred from 10/30/14 and was completed on 11/4/14 by the DON to ensure Licensed Staff was educated.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Residents requiring tracheostomy care have the potential to be affected by this practice. Resident #8 is currently the only resident with a tracheostomy tube in place. Potential admissions of residents with tracheostomy tubes will be reviewed by the Director of Nursing during the Pre-Admission Process. All nurses will be educated regarding tracheostomy care to include maintaining compliance with endotracheal suctioning, by the DON per a skills checklist annually.</p> <p><u>Systematic Changes</u></p> <p>The above education was provided for licensed nurses by the DON from 10/30/14 through 11/4/14 regarding proper tracheostomy care, focusing on maintaining a sterile field and adequate oxygenation/re-oxygenation of the Resident during the endotracheal suctioning process.</p>		

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F 328	<p>Continued From page 2</p> <p>included Anoxic Brain Injury, Systemic Inflammatory Response Syndrome (SIRS), Heart Failure, Sepsis, and Tracheostomy requiring supplemental oxygen.</p> <p>Review of a physician's order dated 09/24/14, revealed Resident #8's physician ordered continuous oxygen at 28 percent via a trach mask, and trach care and suctioning every shift and as needed.</p> <p>Observation of tracheal suctioning and supplemental oxygenation for Resident #8 on 10/29/14 at 9:31 AM revealed Licensed Practical Nurse (LPN) #1 failed to maintain a sterile field during tracheal suctioning by reaching off the sterile field to obtain items that were not sterile. An observation revealed she continued to use the contaminated glove to perform tracheal suctioning and allowed the sterile catheter to contact a non-sterile field on two passes into the trach. Additionally, she failed to provide supplemental oxygenation between passes of the catheter to prevent hypoxia and failed to monitor an oxygen saturation level throughout the procedure.</p> <p>Interview with LPN #1 on 09/29/14 at 9:55 AM, revealed she was not aware she failed to maintain a sterile field or contaminated the catheter and did not realize she failed to provide oxygenation throughout the procedure. She stated she was aware that suctioning a resident withdraws the oxygen from the resident's lungs and that contamination of the sterile field could cause infection to the resident.</p> <p>An interview conducted with the DON on 10/30/14 at 3:45 PM, revealed Resident #8 was at high risk</p>	F 328	<p><u>Systematic Changes Cont.</u></p> <p>In addition, on 11/12/14, the Owner and Licensed Respiratory Therapist from an area Respiratory Care Company provided an in-service for licensed nurses, to include the Director of Nursing, Assistant Director of Nursing, and Unit Supervisors, regarding the proper guidelines for setting up a sterile field, maintaining a sterile field, donning sterile gloves, and guidelines for maintaining oxygenation and re-oxygenation while performing endotracheal suctioning. During their Orientation Period, newly-hired Nurses will be educated by the Assistant Director of Nursing regarding proper guidelines for endotracheal care, focusing on maintaining a sterile field and oxygenating/re-oxygenating the Resident during the endotracheal suctioning process.</p> <p><u>Monitoring</u></p> <p>Nurses performing endotracheal care for Resident #8; focusing on maintaining a sterile field and oxygenation and re-oxygenation during the suctioning process, will be observed by the Director of Nursing weekly for 4 weeks and then monthly. Results of these Observation Audits of endotracheal care/suctioning will be presented by the DON to the monthly PI Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then quarterly.</p>	

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F 328	Continued From page 3 for infection. She further stated the resident required continuous oxygen and a failure to ensure the provision of oxygen to the resident could lead to Hypoxia.  An interview conducted with RN #2/the Administrator on 10/30/14 at 4:07 PM revealed she expected staff to provide special services such as trach care, suctioning, and supplemental oxygen according to the physician's order. She stated Resident #8 was the only resident in the facility who had a trach and she was not aware of any additional training that the facility had provided staff regarding trach care. Her concerns of contamination of the sterile field included an increased risk of infection and the lack of oxygen to this resident could potentially cause Hypoxia.	F 328	<u>Monitoring Cont.</u>  The PI Committee is chaired by the Administrator and consist of the Medical Director, Consulting Pharmacist, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/Laundry Supervisor, MDS/Care Plan Coordinator, Social Services Director, Dietary Supervisor and Activities Director.	12/01/2014	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as Isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the infection Control Program	F 441	F441 <u>Corrective Actions for Targeted Residents</u>  Nurses assigned to care for Resident #8 on 10/30/14 through 11/4/14, to include LPN #1, were educated on setting up a sterile field, maintaining a sterile field, donning sterile gloves, and guidelines for maintaining oxygenation and re-oxygenation while endotracheal suctioning by the Director of Nursing. This education occurred from 10/30/14 and was completed on 11/4/14 by the DON to ensure licensed Staff was educated.		

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F 441	<p>Continued From page 4</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to maintain an Infection Control Program to prevent the development of infection for one (1) of nineteen (19) sampled residents (Resident #8). Observation of tracheal (windpipe) suctioning via Resident #8's tracheostomy (an opening surgically created through the neck into the trachea to allow direct access to the breathing tube) on 10/30/14 revealed staff failed to perform suctioning under sterile conditions as required by the facility's policies.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Tracheostomy Care for disposable Inner Cannulas and Non-Disposable Inner Cannulas," dated</p>	F 441	<p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Residents requiring tracheostomy care have the potential to be affected by this practice. Resident #8 is currently the only resident with a tracheostomy tube in place. Potential admissions of residents with tracheostomy tubes will be reviewed by the Director of Nursing during the Pre-Admission Process. All nurses will be educated regarding tracheostomy care to include maintaining compliance with endotracheal suctioning, by the DON per a skills checklist annually.</p> <p><u>Systematic Changes</u></p> <p>The above education was provided for licensed nurses by the DON from 10/30/14 through 11/4/14 regarding proper tracheostomy care, focusing on maintaining a sterile field and adequate oxygenation/re-oxygenation of the Resident during the endotracheal suctioning process. In addition, on 11/12/14, the Owner and Licensed Respiratory Therapist from an area Respiratory Care Company provided an in-service for licensed nurses, to include the Director of Nursing, Assistant Director of Nursing, and Unit Supervisors, regarding the proper guidelines for setting up a sterile field, maintaining a sterile field, donning sterile gloves, and guidelines for maintaining oxygenation and re-oxygenation while performing endotracheal suctioning. During their Orientation Period, newly-hired Nurses will be educated by the Assistant Director of Nursing regarding proper guidelines for endotracheal care, focusing on maintaining a sterile field and oxygenating/re-oxygenating the Resident during the endotracheal suctioning process.</p>		

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F 441	<p>Continued From page 5</p> <p>November 2008, revealed staff should don sterile gloves and maintain sterile technique throughout tracheostomy care.</p> <p>A review of the facility's policy titled "Suctioning," dated September 2013, revealed a sterile catheter container should be opened avoiding contamination.</p> <p>A review of the facility's reference material titled "Tracheostomy Care," dated February 2014, from Med-Pass Heaton Resources, revealed sterile gloves must be used for trach care. Further review of the facility's reference material titled "Suctioning the Lower Airway (Endotracheal or Tracheostomy Tube)," dated October 2010, from Med-Pass Heaton Resources, revealed sterile technique must include maintaining a sterile dominant hand for suctioning.</p> <p>An interview conducted with the Director of Nursing (DON) on 10/30/14 at 3:45 PM, revealed staff performing tracheal suctioning and trach care should maintain a sterile field. She stated contamination of the sterile field would include an increased risk of infection for the resident.</p> <p>Record review revealed the facility admitted Resident #8 on 08/27/12 with diagnoses that included Anoxic Brain Injury, Systemic Inflammatory Response Syndrome (SIRS), Heart Failure, Sepsis, and Tracheostomy requiring supplemental oxygen.</p> <p>A review of Resident #8's physician's orders dated 09/25/14 and comprehensive plan of care with a goal target date of 12/26/14 revealed the resident required trach care and suctioning every shift and as needed (PRN).</p>	F 441	<p><u>Monitoring</u></p> <p>Nurses performing endotracheal care for Resident #8; focusing on maintaining a sterile field and oxygenation and re-oxygenation during the suctioning process, will be observed by the Director of Nursing weekly for 4 weeks and then monthly. Results of these Observation Audits of endotracheal care/suctioning will be presented by the DON to the monthly PI Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then quarterly.</p> <p>The PI Committee is chaired by the Administrator and consist of the Medical Director, Consulting Pharmacist, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/Laundry Supervisor, MDS/Care Plan Coordinator, Social Services Director, Dietary Supervisor and Activities Director.</p>	12/01/2014

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F 441	<p>Continued From page 6</p> <p>A review of Resident #8's medical record revealed the resident was admitted to the local hospital on five occasions within the past six months with diagnoses including respiratory distress, low oxygen level, and pneumonia.</p> <p>Observation of tracheal suctioning and supplemental oxygenation for Resident #8 on 10/29/14 at 9:31 AM revealed Licensed Practical Nurse (LPN) #1 failed to maintain a sterile field during tracheal suctioning by reaching off the sterile field to obtain items that were not sterile. An observation revealed she continued to use the contaminated glove to perform tracheal suctioning and allowed the sterile catheter to contact a non-sterile field on two passes into the trach. Additionally, she failed to provide supplemental oxygenation between passes of the catheter to prevent hypoxia and failed to monitor an oxygen saturation level throughout the procedure.</p> <p>Interview with LPN #1 on 09/29/14 at 9:55 AM, revealed she was not aware she failed to maintain a sterile field or contaminated the catheter and that contamination of the sterile field could cause infection to the resident.</p> <p>An Interview conducted with the DON on 10/30/14 at 3:45 PM, revealed Resident #8 was at high risk for infection. The DON stated to her knowledge the facility had not provided any formal training or education to the staff regarding trach care or suctioning.</p> <p>An Interview conducted with RN #2/the Administrator revealed that she was previously the DON of the facility and was not aware of any</p>	F 441			

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F 441	Continued From page 7 formal training or education provided to the staff on trach care or suctioning.	F 441			