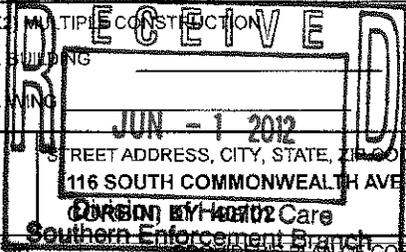


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/03/2012
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 Division of Health Care Southern Enforcement Branch
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY18216) was initiated on 04/24/12, and a standard health/extended survey was conducted on 05/01/12-05/03/12. The complaint was substantiated with deficient practice identified.</p> <p>Immediate Jeopardy was identified on 04/25/12, and determined to exist on 04/18/12. The facility was notified on 04/25/12. Observation, interview, and record review revealed the facility failed to have an effective system in place to ensure staff assessed residents when a change in condition was identified and to ensure staff immediately initiated emergency medical care when a resident, who was designated a Full Code, stopped breathing. On 04/18/12, at 5:35 PM, Resident #1's family reported to Licensed Practical Nurse (LPN) #1 that Resident #1 had stopped breathing. However, LPN #1 did not assess the resident and did not provide immediate emergency interventions when the family reported the change in condition. LPN #1 left the room, upon the family reporting the resident had stopped breathing, to verify the resident's code status by reviewing the medical record located at the nurses' desk. According to the ambulance report from 04/18/12, facility staff contacted 911 at 5:38 PM, three minutes after the family reported the resident ceased to breathe. According to interview with LPN #1, it was two to three minutes before facility staff re-entered Resident #1's room to initiate emergency care. Review of the Emergency Room record revealed Resident #1 was pronounced dead on arrival at 6:22 PM.</p> <p>Deficiencies were cited at 42 CFR 483.25 Quality</p>	F 000	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required by the provision of federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bill Collins</i>	TITLE ADMINISTRATOR	(X6) DATE 06/01/2012
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1 of Care (F309), 42 CFR 483.75 Administration (F490), and Quality Assurance (F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F309).</p> <p>An acceptable Allegation of Compliance was received on 04/30/12, which alleged removal of Immediate Jeopardy on 04/29/12. The State Agency determined the Immediate Jeopardy was removed on 04/29/12, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.25 Quality of Care (F309), 42 CFR 483.75 Administration (F490), and Quality Assurance (F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>Additional deficiencies were cited as a result of the standard health survey.</p>	F 000		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge</p>	F 157	<p>F157</p> <ol style="list-style-type: none"> 1. Resident #1 has expired. 2. All other residents were reviewed for notification to the physician, resident and family by utilization of the 24 hour report to identify significant changes in condition: Physical, mental, psychosocial, medication, alteration of treatment and labs by nurse's managers on 5/16/2012. 3. Nursing staff were re-educated as to the need to notify the physician, resident and family of significant changes in condition: Physical, mental, 	

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F 157	<p>Continued From page 2</p> <p>the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy it was determined the facility failed to notify the family of a change in condition and a need to alter treatment for one of twenty-one sampled residents (Resident #1). Physician's orders were obtained for Resident #1 to be started on oxygen for a low oxygen level, and for medications to be altered due to oversedation. However, the family was not informed of these changes.</p> <p>The findings include:</p> <p>A review of facility's policy, "New Symptoms, Signs, and other Changes in Condition," dated 02/01/12, revealed it was the goal of the facility for a licensed nurse to do a thorough assessment on each resident as the condition changed and to notify the resident, responsible party, and</p>	F 157	<p>psychosocial, medication, alteration of treatment and labs on 4/26/2012.</p> <p>The Notification Policy and procedure was reviewed 4/26/2012 by the Administrator and the Director of Clinical Support Services (DCSS).</p> <p>4. Notification of the physician, resident and family for significant change in condition will be audited and education given as needed by the unit managers utilizing 25% of new physician orders validating notification through documentation on new physician orders and nursing notes 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks then as recommended by the Quality Assurance Committee.</p> <p>These audits will be presented to the Director of Nursing who will review the findings with the Administrator. The Administrator will take the audit results to the Quality Assurance committee monthly and review with Medical director quarterly to ensure continued compliance.</p>	05/30/12
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F 157	<p>Continued From page 3</p> <p>physician. Some examples of changes that required family to be notified immediately were a significant change in the resident's mental, physical, or psychosocial status, or a need to alter treatment.</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 04/16/12, with diagnoses to include debility. The resident had admission orders for Prednisone (corticosteroid) 20 milligrams (mg) by mouth once a day, Temazepam (sedative-hypnotic) 30 mg by mouth at hour of sleep, and Xanax (anxiolytics) 0.5 mg by mouth two times a day.</p> <p>A review of nursing notes revealed on 04/17/12, Resident #1 experienced shortness of breath and his/her oxygen saturation was at 86 percent. The physician was notified and an order was obtained for oxygen at 2 liters per nasal canula. A review of physician's orders revealed on 04/17/12, orders for oxygen at 2 liters per nasal canula for oxygen saturation of 86 percent. Further review of nursing notes revealed on 04/18/12, a note that the resident's physician had visited and written new orders for labs to be obtained, and for medications to be changed. The nursing note stated family was aware.</p> <p>Further review of physician's orders revealed an order on 04/18/12, for labs to be obtained, to decrease the Temazepam medication to 15 mg at hour of sleep as needed, to decrease the Xanax medication to 0.25 mg twice a day as needed, and to decrease the Prednisone medication by 2.5 mg each week as tolerated.</p> <p>Interview with Resident #1's family member #1,</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>on 04/25/12, at 4:01 PM, revealed the facility had not contacted the family for anything since the resident's admission to the facility on 04/16/12. The family member stated she was not aware Resident #1's oxygen saturation had dropped and oxygen was being administered, or that the resident's medications had been changed. Family member #1 further stated she called the facility on 04/18/12, to inquire about Resident #1's condition and was told by the nurse on duty that she (the nurse) had been off work and did not know anything about Resident #1.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 04/25/12, at 9:56 AM, revealed she was the primary nurse who provided care for Resident #1 on 04/17/12 and 04/18/12 during the day shift when the physician's orders were obtained, LPN #3 stated she could not remember if she contacted Resident #1's family about the changes in the resident's condition and treatment changes. The LPN further stated she "may have not called family" related to the oxygen order, that she "may have gotten busy." Further interview revealed when the LPN wrote the order, she also documented the family was notified before actually contacting the family. She further stated she "probably had tried to call" but "maybe got busy" and forgot to call regarding the change in medication and the lab orders.</p>	F 157		
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>	F 226	<p>F226</p> <ol style="list-style-type: none"> Residents # 20 and #21 have shown no negative outcome from the unsubstantiated allegations. All residents have the potential to be 	

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F 226	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, facility investigation review, and facility policy review, it was determined the facility failed to implement policies and procedures for reporting two allegations of abuse made by Resident #2 and Resident #20. Although the facility conducted investigations of the two allegations of abuse and found the allegations were unsubstantiated, the facility failed to report the allegations to the appropriate agencies as required.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Reporting & Prevention policy updated July 2001, revealed all reports of actual or suspected abuse of a resident must be directed to the Administrator or designee immediately and the Administrator or designee will make the initial report of possible abuse to the Department for Community Based Services, Adult Protective Services, and Licensure and Regulation. The policy stated, "The Administrator, or designee, immediately reports the incident to the appropriate state agencies..."</p> <p>Review of the facility's investigation dated 03/04/12, revealed Resident #2 reported an allegation of sexual abuse to Certified Nursing Assistant (CNA) #11. Resident #2 alleged Resident #15 raped Resident #21 during the night of 03/03/12. The investigation revealed the staff informed Unit Manager #1 about the allegation, who notified the on-call Administrative staff who in turn notified the Administrator and Director of Nursing. The investigation revealed</p>	F 226	<p>affected by acts of abuse and/or neglect. The staff does report suspected issues immediately to their supervisor, who immediately reports these allegations to the Administrator. All allegations will continue to be investigated immediately. No other allegations were found to be reported.</p> <p>3. The VP of Older Adults did re-educate the Administrator on the reporting requirements of all allegation prior to investigation as found in the Abuse Reporting and Prevention Policy on 5/23/2012. The Administrator will be the only reporter to OIG, APS and law enforcement of allegations of abuse or neglect.</p> <p>The Administrator will log all allegations on the Abuse/ Neglect reporting log that includes the time and date of the initial report to the Administrator, OIG, APS and law enforcement.</p> <p>The VPOA will review the log monthly for time and date of the initial report to the Administrator, OIG, APS and law enforcement, beginning May 23, 2012 for 6 months and continuing for 2 subsequent quarters.</p> <p>4. The Administrator will review the logs with the Medical Director quarterly for time and date of the initial report to the Administrator,</p>	

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F 226	<p>Continued From page 6</p> <p>"Administrator and Director of Nursing (DON) discussed the concern via telephone and it was decided that the information obtained thus far was not criminal in nature and did not need to be reported in two hours."</p> <p>Review of the facility's investigation dated 04/07/12, revealed Resident #20 reported to the resident's family member that CNA #13 said she could help the resident's hemorrhoids and then put her finger in the resident's rectum and the resident started bleeding from the rectum. Review of the investigation further revealed Resident #20's nephew informed Licensed Practical Nurse (LPN) #7 of the allegation, who reported the allegation to Unit Manager (UM) #1, who reported the allegation to the DON.</p> <p>Interview with the DON on 05/03/12, at 2:30 PM, revealed even though the facility's policy stated allegations would be "immediately" reported she believed due to the Elder Justice Act the facility had two hours to decide if the allegation was criminal. She further revealed the facility had 24 hours to report any allegation of abuse the facility was unable to resolve or substantiate, according to facility practice and policy. The interview revealed after investigating Resident #2's allegation, the resident had only heard a commotion and did not visually witness Resident #15 abuse anyone, so the DON felt there was nothing to report to the state agencies. The interview further revealed after investigating Resident #20's allegation, the staff member accused had not worked with the resident in approximately a year, so again the DON did not feel there was anything to report to the state agencies.</p>	F 226	OIG, APS and law enforcement at the Quality Assurance Committee meetings for 4 quarters.	05/30/12

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F 226	<p>Continued From page 7</p> <p>Interview with the Administrator on 05/03/12, at 4:00 PM, revealed even though the facility's policy stated allegations would be "immediately" reported he believed the facility had two hours to report any criminal allegation due to the Elder Justice Act and had 24 hours to report other allegations of abuse, according to facility practice and policy. The Administrator stated he made the decision not to report Resident #2's allegation of sexual abuse because the resident did not witness the incident. The resident assumed from the commotion that the allegation happened. The interview further revealed the Administrator made the decision not to report Resident #20's allegation because CNA #13, who was accused, had not worked with the resident for several months.</p> <p>Review of the facility's Statement of Deficiencies (SOD) dated 03/25/11, revealed "J" level deficiencies were issued during an abbreviated survey for not reporting an allegation of neglect. Review of the Plan of Correction (POC) for the 03/25/11 deficiencies revealed on 03/02/11, the Administrator and DON were re-educated on identification and investigation of abuse/neglect "as well as their duty to report suspected abuse and neglect to the appropriate agencies timely."</p> <p>The State Agency investigated both of the above allegations during the survey after identifying these allegations had not been reported. The investigation determined both allegations were unsubstantiated; however, the facility failed to report the allegations.</p>	F 226		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	F309 1. Resident #1 has expired.	

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F 309	<p>Continued From page 8</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, policy review, review of American Heart Association Basic Life Support for healthcare providers, Kentucky Board of Nursing Advisory Opinion Statement, and review of the ambulance transfer report it was determined the facility failed to ensure staff assessed one of twenty-one sampled residents (Resident #1) when the resident had a change of condition and failed to ensure staff immediately initiated emergency medical care when the resident stopped breathing.</p> <p>On 04/18/12, family members noted a change in Resident #1's condition and summoned Licensed Practical Nurse (LPN) #1 to the resident's room. At 5:35 PM, while LPN #1 was in the resident's room, the family reported to the nurse that Resident #1 had stopped breathing. LPN #1 left Resident #1's room to check the resident's code status without first assessing the resident's condition and initiating emergency care as needed. According to documentation from the ambulance service, 911 was called at 5:38 PM on 04/18/12, three minutes after Resident #1 experienced the change of condition. Nursing notes revealed staff did not start Cardio</p>	F 309	<p>2. All resident can be affected. On April 25, 2012 all residents had their charts audited to ensure physicians orders for current code status and care plans reflected the current code status by the unit managers and staff development coordinator. On April 25, 2012 a licensed nurse began rounds to ensure no residents were in any acute cardiac or respiratory distress and a C.N.A continued to make 30 minute rounds until all residents that were full code status had a yellow wristbands in place. On April 25, 2012 a licensed nurse completed a cardio/pulmonary assessment on all residents. On April 25, 2012 the unit manager or staff development coordinator placed a yellow wristband on the arm of all residents with a verified full code status. A physician's order was obtained on April 28, 2012, for nurses to check residents who were a full code for a yellow wristband placement each shift. Beginning April 25, 2012 the licensed nurse checked all residents with yellow wristband every shift to ensure the wristband remained in place, and documents on the residents medication administration record, indicating the yellow bracelet was in place.</p> <p>3. Beginning on April 25, 2012 all nursing staff was re-educated on</p>	
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F 309	<p>Continued From page 9</p> <p>Pulmonary Resuscitation (CPR) until 5:40 PM, approximately five minutes after Resident #1 experienced a change of condition. Resident #1 was pronounced dead upon arrival to the Emergency Room at 6:22 PM.</p> <p>The failure of the facility to ensure residents who experienced a change of condition were assessed promptly and immediately provided emergency medical care as needed placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care was identified on 04/25/12, and determined to exist on 04/18/12. The facility was notified of the Immediate Jeopardy on 04/25/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/30/12, with the facility alleging removal of the Immediate Jeopardy on 04/29/12. Immediate Jeopardy was verified to be removed on 04/29/12, as alleged prior to exiting with the facility on 05/03/12, with remaining noncompliance at 42 CFR 483.25 Quality of Care, with a scope and severity of "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance.</p> <p>The findings include:</p> <p>A review of the facility's policy, "New Symptoms, Signs and other Changes of Condition," dated 02/01/12, revealed it was the goal of the facility for a licensed nurse to do a thorough assessment on each resident as their condition changed and to notify the resident, responsible party and the physician.</p>	F 309	<p>revised code status policy and procedure that included the placement of yellow wristbands to designate full code status, by the DCSS, the DON, the SDC, and the UM's. The re-education included the necessity for immediate action by the nurse when upon assessment a resident was found to have a change in condition. This education was completed in person and by telephone prior to any nurse caring for the resident and completed on April 26, 2012. The staff competency was insured by having them verbalize the change in this policy. On April 28, 2012 the DON the DCSS, UM's and the SDC re-educated all licensed staff on assessment skills and verified competency with return demonstration. The education did include;</p> <p>(a) Head to toe assessments. (b) The assessment focused on the primary organs such as heart, lungs, and pupils and how to properly assess each, along with normal findings and abnormal findings on assessment.</p> <p>On April 27, 2012 the DON, the SDC, and the UM's re-educated the nurses to respond and act</p>	

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F 309	<p>Continued From page 10</p> <p>A review of the facility's policy, "Full Code Status verses No Code-DNR," not dated, revealed if a resident did not have a "no code-DNR" physician's order, the resident was considered to be a "Full Code." Upon finding the resident with no pulse and not breathing," a Full Code was required to be initiated with chest compression and breaths, and 911 was to be called immediately.</p> <p>A review of the facility's policy, "Guidelines to take in a full code situation," dated 03/03/11, revealed the first nurse responder was to verify code status, by checking the resident's medical record to ensure the resident was a Full Code and then was to direct the actions of other staff members.</p> <p>A review of the American Heart Association (AHA), Basic Life Support (BLS) for Healthcare Providers, Guidelines for CPR 2010, revealed a critical concept for high quality CPR was to start compressions within ten seconds of recognition of cardiac arrest. According to the AHA, the first step for adults is to assess the victim for response and look for normal or abnormal breathing. If there is no response and no breathing or no normal breathing, shout for help. The healthcare provider should not delay activating the emergency response system but should check the victim simultaneously for response and breathing. The rescuer should activate the emergency response system and begin CPR if the adult victim is unresponsive and not breathing or not breathing normally and has no pulse. If within ten seconds no pulse is found or if the rescuer is not sure of a pulse begin chest compression.</p>	F 309	<p>immediately upon an assessed change of condition in the resident status.</p> <p>All new nursing staff will be educated and tested through return demonstration on their assessment skills, code status, and actions to take when the resident is assessed to have a change in condition prior to caring for resident. The new staff will be required to complete a posttest to ensure comprehension of the policies.</p> <p>The admitting nurse will place a yellow wristband on the wrist of all residents admitted to the facilities that choose a full code status.</p> <p>The SDC and/or UM's will audit ten Nursing staff members weekly to ensure comprehension of the code status policy, assessment skills, and actions to take when a resident is identified with a change in condition for 4 weeks, then 5 Nursing staff members per week for 4 weeks, then as recommended by the QA committee. The UM will audit the 24-hour nursing report for assessment findings as well as what immediate actions were taken, based upon the assessment findings, to care for the resident with a change of condition 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks then as</p>	

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F 309	<p>Continued From page 11</p> <p>A review of KRS 314.021(2) revealed all individuals licensed under provisions of this Chapter shall be responsible and accountable for making decisions that are based upon the individual's educational preparations and experience in nursing and shall practice nursing with reasonable skill and safety. A review of the Kentucky Board of Nursing Advisory Opinion Statement, AOS #36 Resuscitation (approved 02/08) revealed the accountability would include the responsibility of knowing the code status of the nurse's assigned patients.</p> <p>A review of the facility's investigation revealed on 04/18/12, at approximately 5:35 PM, LPN #1 and Resident #1's family were in the resident's room. LPN #1 touched the resident's wrist to get a pulse and noticed the resident's forearms were moist underneath and swollen. Further review revealed the LPN was going to obtain a blood glucose machine (machine that checks the blood sugar level) and as she turned to leave the room the family members stated, "Ma'am, Ma'am, [Resident #1's] not breathing." According to the investigation, LPN #1 stated she turned and saw the resident taking "shorter more shallow breaths," and one of the family members started chest compressions as the LPN ran out into the hallway.</p> <p>A review of Resident #1's medical record revealed the resident was admitted on 04/16/12, with a diagnosis of Debility, and the resident was a Full Code.</p> <p>Interview with LPN #1 on 04/25/12, at 8:41 AM, revealed she was in Resident #1's room discussing the resident's condition with the</p>	F 309	<p>recommended by the Quality Assurance Committee.</p> <p>The DON will review the UM's audits and will present the findings to the Administrator. UM's will audit the MAR's of the residents that have chosen a full code status three times weekly to ensure licensed nurses have completed the required yellow wristband checks for 4 weeks, then weekly for 4 weeks, then monthly or as recommended by the QA Committee. The Administrator will review the UM's MAR audits to ensure completeness and present the findings to the quarterly quality assurance meetings. The UM will check all newly admitted resident admission paperwork for the selected code status. They will also check the resident for the appropriate wristband, and check the MAR to ensure the wristband checks are documented on the MAR.</p> <p>A Mock Code as outlined in guidelines to take in a full code situation (see exhibit A) that includes the response time of the staff to begin treatment will be run monthly for 6 months then quarterly.</p> <p>The Administrator will take the audit results and Mock Code results including time of response to the Quality Assurance committee monthly and review with Medical director quarterly to ensure continued compliance.</p>	05/30/12
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F 309	<p>Continued From page 12</p> <p>resident's family at approximately 5:35 PM on 04/18/12, when the LPN noticed the resident's arms were edematous and the right arm was cool and moist to touch. LPN #1 stated she explained to the family that she was going to check the resident's blood glucose level when she noticed the resident's respirations were shallow. The LPN proceeded to leave the room but a family member said, "Ma'am, Ma'am." The nurse turned around and said she was going to check the resident's code status. According to LPN #1, family member #1 stated Resident #1 was a Full Code, and that Resident #1 was "not breathing." LPN #1 stated when she looked at the resident she did not see the resident breathing, and one of the family members started CPR. LPN #1 stated she left the room. Interview further revealed the LPN went to the nurses' desk to verify the resident's code status and then proceeded to send another nurse into the room to start CPR while LPN #1 paged the "code" over the intercom, and called 911. Further interview with LPN #1 revealed it was two to three minutes from the time she was in the room and the resident's family stated the resident was not breathing until another staff member went into the room to perform CPR.</p> <p>Further interview with LPN #1 on 04/27/12, at 3:24 PM, revealed when a resident stopped breathing it was considered a change in condition, and when a resident experienced a change in condition, the nurse was required to assess the resident. LPN #1 further stated when a resident stopped breathing the nurse should go to the resident, say the resident's name, and attempt to arouse the resident. LPN #1 stated she assessed the resident by standing</p>	F 309		

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F 309	<p>Continued From page 13</p> <p>approximately five feet away and observed for respirations when the family stated the resident was not breathing. LPN #1 further stated after she observed Resident #1 with "shallow breathing all I was worried about was finding out [his/her] code status" (during the first interview with LPN #1 two days prior, she stated the resident was not breathing when she left the room). Interview revealed the LPN left the resident's room without first assessing the resident's change in condition and without initiating emergency medical interventions.</p> <p>A review of Resident #1's nursing notes dated 04/18/12, at 5:35 PM, revealed LPN #1 was in the room with Resident #1 and the resident's family members when the LPN felt the resident's right arm and noted the arm to be cool to touch with moisture under the forearm. The nurse was leaving the room to obtain a blood glucose machine when the resident's respirations "became shallow." The nurse then left the room to check the resident's medical record for the resident's code status. At 5:40 PM, the nurse's notes stated a code was called, along with the ambulance service, and CPR was initiated by other nurses.</p> <p>Interview with Resident #1's family member #1 on 04/25/12, at 4:25 PM, revealed she and another family member visited with Resident #1 on 04/18/12. Family member #1 stated when she walked into the resident's room the resident was "unresponsive" and oxygen was being administered. Family member #1 stated the nurse was asked to come to the room immediately after the family members observed the resident. Family member #1 stated she had</p>	F 309		
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F 309	<p>Continued From page 14</p> <p>called earlier in the day on 04/18/12, to inquire about the resident and was told by the resident's nurse that she (the nurse) had been off for a while and did not know anything about the resident. The family member proceeded to explain to LPN #1 that "this ain't right," that the resident was at the facility for rehab to strengthen the legs, and the resident was alert and talking when the resident was admitted two days prior. Family member #1 stated she told the nurse she "had to get [Resident #1] out of here" and when she touched the resident the resident was "clammy, sticky." Family member #1 further stated that family member #2 informed the nurse the resident's eyes were "fixed" and the resident was "not breathing." According to family member #1, LPN #1 did not assess the resident for breathing and instead left the room after she was informed the resident was not breathing. The two family members proceeded to lay the resident's bed back and family member #2 initiated CPR. Family member #1 stated at one point while family member #2 was performing CPR, Resident #1 "gulped," trying to get air, and they turned the resident to a side lying position because the resident had "all kinds of stuff" in the resident's lungs. Family member #1 stated it was three to four minutes before facility staff re-entered the resident's room to provide emergency care.</p> <p>Interview with Resident #1's family member #2 on 04/27/12, at 11:32 AM, revealed he and another family member visited Resident #1 on 04/18/12. The family member stated the two family members and the LPN were in the room, and Resident #1 had labored breathing and audible gurgling in the airway. Family member #2 stated to LPN #1 that the resident's eyes were "fixed"</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>and then said, "Ma'am, [Resident #1] isn't breathing." Family member #2 stated the nurse proceeded to leave the room. Interview further revealed family members #1 and #2 proceeded to lay the bed back. Then family member #2 started chest compressions, and after giving one breath, family member #2 stated Resident #1 made a face as if maybe the resident had gotten air. Family member #2 proceeded to give another round of compressions and when he was preparing to give another breath Resident #1 gasped. Family member #1 and family member #2 proceeded to roll the resident into a side position. The family member stated he then rolled the resident onto the back side again and gave another round of compressions. Family member #2 further stated he performed three sets of thirty compressions and breaths, which took approximately two minutes, and repositioned the resident two times before facility staff came into the room to assume CPR. Further interview revealed when the family member told the nurse the resident was not breathing the nurse did not assess the resident's status, nor did the nurse do anything to provide immediate intervention for Resident #1.</p> <p>A review of the ambulance report dated 04/18/12, revealed the facility called ambulance Dispatch at 5:38 PM (three minutes after Resident #1 experienced a change in condition per nursing notes) to request assistance at the facility. The ambulance arrived at the facility at 5:41 PM.</p> <p>Interview with Paramedic #1 on 04/25/12, at 12:00 PM, revealed his team was dispatched to the facility at 5:38 PM, and arrived at 5:41 PM. Upon entering the room, he observed staff</p>	F 309		

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F 309	<p>Continued From page 16</p> <p>performing CPR. Paramedic #1 stated Resident #1 was ashen color, and he was told by a staff member the resident had "been down" about 15 minutes and family had initiated CPR. Further interview revealed the paramedic suctioned "quite a bit" of "brown colored" secretions from the resident's mouth. Paramedic #1 stated Resident #1 was intubated by the paramedics and the resident's pacemaker still showed a rhythm on the monitor, but that Resident #1 was asystole (no heart beat).</p> <p>A review of the hospital report from 04/18/12, revealed Resident #1 was pronounced dead at 6:22 PM upon arrival to the hospital.</p> <p>Interview with Resident #1's physician on 04/25/12, at 10:55 AM, revealed 04/18/12 was the first time the physician had treated Resident #1. Further interview revealed when the physician saw the resident on 04/18/12, Resident #1 was "not very coherent" and the physician felt the resident may have been oversedated. Interview further revealed he would "assume" facility staff was aware of each resident's code status and would start emergency procedures when needed. The physician stated facility staff could not leave the room during an emergency and that they needed to have "some way of knowing" each resident's code status. The physician stated three minutes was too long to wait to begin CPR.</p> <p>Interview with the Director of Nursing (DON) on 04/26/12, at 5:25 PM, revealed LPN #1 followed the facility's policy by leaving the room when the resident ceased to breathe on 04/18/12. The DON further stated the nurse was always supposed to look at the resident's medical record</p>	F 309		

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F 309	<p>Continued From page 17</p> <p>to verify the resident's code status prior to initiating resuscitative measures. The DON further stated it was acceptable to leave Resident #1 not breathing because "the new standards in CPR" were to "call 911 first." The DON further stated on 04/27/12, at 4:30 PM, that a resident's respiratory status could be visualized from five feet away by observing if the chest was rising. The DON further stated that LPN #1 had listened to Resident #1's chest at "supper time" and did not expect her to assess the lung sounds again when the family told LPN #1 that the resident was not breathing.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 04/30/12, which alleged removal of IJ effective 04/29/12. A standard health/extended survey was conducted on 05/01-03/12, which determined the IJ was removed on 04/29/12 as alleged.</p> <p>--A review of the AOC revealed the following:</p> <p>On 04/25/12, the Unit Managers (UM) and Staff Development Coordinator (SDC) audited all resident charts to ensure the physician's orders for current code status and care plans reflected the current code status.</p> <p>On 04/25/12, the Administrator and Director of Nursing (DON) reviewed and revised the facility's Code Status policy to include the utilization of yellow wristbands to designate Full Code status for residents.</p> <p>On 04/26/12, the Medical Director reviewed and approved the revised Code Status policy.</p>	F 309		

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F 309	<p>Continued From page 18</p> <p>On 04/25/12, the SDC verified current cardiopulmonary (CPR) certifications for all current licensed nurses providing direct care for residents.</p> <p>On 04/25/12, a licensed nurse began rounds to ensure no residents were in any acute cardiac or respiratory distress and a CNA continued to make 30-minute rounds until all residents that were Full Code status had a yellow wristband in place.</p> <p>On 04/25/12, a licensed nurse completed a cardio/pulmonary assessment on all residents.</p> <p>On 04/25/12, the UM or the SDC placed a yellow wristband on the arm of all residents with a verified Full Code status.</p> <p>Beginning on 04/25/12, nursing staff checked all residents with yellow wristbands every four hours to ensure the wristband remained in place. The 4-hour checks continued for the next 72 hours. Then a licensed nurse checked all residents with yellow wristbands every shift to ensure the wristband remained in place, and documented on the resident's Medication Administration Record (MAR), indicating the yellow bracelet was in place. These checks will be ongoing.</p> <p>A physician's order was obtained as of 04/28/12, for nurses to check residents who were a Full Code for yellow wristband placement each shift.</p> <p>Beginning on 04/25/12, all nursing staff was re-educated on the revised Code Status policy/procedure that included the placement of yellow wristbands to designate Full Code status,</p>	F 309		

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F 309	<p>Continued From page 19</p> <p>by the Director of Clinical Support Services, the DON, the SDC, and the UMs. The re-education included the necessity for immediate action by the nurse when upon assessment a resident was found to have a change of condition and also included the following:</p> <p>(a) If a resident is in cardiac/respiratory distress, the nurse should check for the yellow wristband, go into the hall, yell for assistance, and immediately return to the resident for further assessment and actions based upon assessment findings.</p> <p>(b) If the resident is without a pulse and/or breathing, the nurse will check for the yellow wristband. If a wristband is in place, the nurse will go to the hall, yell for assistance, and return to the resident and begin chest compressions.</p> <p>(c) If the resident is without a pulse and/or breathing, the nurse will check for the yellow wristband. If no wristband is in place, the nurse will go to the hall, yell for assistance, and return to the resident. When assistance arrives, the nurse will send someone to the medical record to confirm the resident is a no code. If the resident's medical record states the resident is a Full Code, the nurse at bedside will begin chest compressions.</p> <p>(d) If the resident has a non-emergency change in condition, the nurse is to conduct a thorough assessment, based on the body system(s) affected, and notify the physician for further actions.</p> <p>This re-education was completed in person and</p>	F 309		

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F 309	<p>Continued From page 20</p> <p>by telephone prior to any nursing staff caring for residents and completed on 4/26/12. The staff's competency was ensured by having them verbalize the change in this policy.</p> <p>On 04/28/12, the DON, the Director of Clinical Support, the UM, and the SDC re-educated all licensed staff on assessment skills and verified competency with a return demonstration. The education included:</p> <p>(a) Head to toe assessments.</p> <p>(b) The assessments focused on the primary organs such as the heart, lungs, and pupils and how to properly assess each, along with normal findings and abnormal findings on assessment.</p> <p>On 04/27/12, the DON, the SDC, and the UMs re-educated the nurses to respond and act immediately upon an assessed change of condition in a resident's status.</p> <p>All new nursing staff will be educated on the Code Status policy, physical assessments (normal versus abnormal), and changes in condition prior to care for the resident. The new staff will be required to complete a posttest to ensure comprehension of the policies.</p> <p>All new nursing staff will be educated and tested through return demonstration on their assessment skills, Code Status, and actions to take when a resident is assessed to have change in condition prior to caring for a resident.</p> <p>The SDC and/or UMs will audit ten nursing staff members weekly to ensure comprehension of the</p>	F 309		

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F 309	<p>Continued From page 21</p> <p>Code Status policy, assessment skills, and actions to take when a resident has a change in condition.</p> <p>The UMs will audit the 24-hour nursing report five days a week for assessment findings as well as what immediate actions were taken, based upon assessment findings, to care for the resident with changes.</p> <p>The DON will review the UMs' audits and will present the findings at the quarterly Quality Assurance (QA) meetings.</p> <p>The UMs will audit the Medication Administration Records (MARs) of the residents that have chosen a Full Code status three times weekly to ensure the licensed nurses have completed the required yellow wristband checks.</p> <p>The Administrator will review the UMs' MARs audits to ensure completeness and present the findings at the quarterly QA meetings.</p> <p>The Admitting nurse will place a yellow wristband on the wrist of all residents admitted to the facility who choose a Full Code status.</p> <p>The UMs will check all newly admitted residents' admission paperwork for the selected code status, check the resident for the appropriate wristband, and check the MARs to ensure the wristband checks are documented on the MAR.</p> <p>—The surveyors validated the corrective actions taken by the facility as follows:</p> <p>A review of the chart audits conducted by the</p>	F 309		

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F 309	<p>Continued From page 22</p> <p>facility on 04/25/12, revealed the UMs and the SDC had audited all residents' charts to ensure the residents' physician's orders and care plans reflected the proper code status.</p> <p>Record reviews of 16 residents on the Third Floor and 13 residents on the Second Floor revealed the residents had physician's orders for Full Code status, had care plan interventions addressing the resident's Full Code status, and the residents' charts had the appropriate code status identified.</p> <p>Interviews on 05/03/12, at 4:00 PM, with UM #1, at 3:45 PM, with UM #2, and at 4:05 PM, with UM #3 revealed each resident's code status, physician's orders, and care plans were verified to ensure the reflection of the appropriate code status by the UM.</p> <p>Interview on 05/03/12, at 5:15 PM, with the SDC revealed she assisted in checking all residents' physician's orders, advance directives, and care plans to verify residents' code status was appropriately reflected.</p> <p>Review of the Code Status policy revealed the policy was revised to include the utilization of a yellow wristband to designate Full Code status, which was approved and signed by the Medical Director on 04/26/12.</p> <p>Interviews on 05/03/12, at 4:00 PM, with the Administrator, and at 2:30 PM, with the DON, revealed the Vice President of Operations, the Nurse Consultant, the Medical Director, the Administrator, the DON, and the SDC met and discussed changes that needed to be made to the facility's Code Status policy on 04/25/12. The</p>	F 309		

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F 309	<p>Continued From page 23</p> <p>interviews revealed after the group agreed on the changes that were required, the policy was revised, and the Medical Director reviewed and signed the revised Code Status policy on 04/26/12.</p> <p>A review of the CPR certification audits revealed the SDC had audited all current licensed nurses providing direct care for current CPR certification on 04/25/12.</p> <p>Interview with the SDC on 05/03/12, at 5:15 PM, revealed the SDC had maintained a list of all current Cardiopulmonary Resuscitation (CPR) certifications to ensure staff was appropriately trained to administer CPR.</p> <p>A review of the nurses' rounds audits revealed licensed nurses conducted rounds on 04/25/12, to ensure residents were not experiencing any acute cardiac or respiratory distress until all yellow wristbands were in place on all residents identified to be Full Code status.</p> <p>Interviews on 05/03/12, at 4:00 PM, with UM #1, at 3:45 PM, with UM #2, and at 4:05 PM, with UM #3 revealed the UMs assessed all residents' cardiac and respiratory status on the second and third floor to ensure the residents were in no distress until all yellow wristbands were applied to all residents' wrists who were Full Code status on 04/25/12.</p> <p>A review of CNA rounds revealed CNAs conducted rounds every 30 minutes on 04/25/12, to ensure residents were not experiencing any distress until all yellow wristbands were in place on all residents identified to be Full Code status</p>	F 309		

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F 309	<p>Continued From page 24 on 04/25/12.</p> <p>Interviews conducted on 05/03/12, at 3:25 PM, with CNA #17, and at 4:35 PM, with CNA #11 revealed they monitored residents every 30 minutes for distress while the yellow wristbands were being placed on the residents identified to be Full Code status and continued the 30-minute rounds until the yellow wristbands were in place for all residents with Full Code status on 04/25/12.</p> <p>A review of the cardio/pulmonary assessments revealed licensed nurses completed cardio/pulmonary assessments on all residents on 04/25/12.</p> <p>Interviews on 05/03/12, conducted at 4:00 PM, with UM #1, at 3:45 PM, with UM #2, and at 4:05 PM, with UM #3 verified a cardio/pulmonary assessment was completed on 04/25/12, for all residents.</p> <p>A review of the yellow wristband verification audit revealed the UMs and/or the SDC verified all residents identified to be Full Code status had a yellow wristband in place on 04/25/12.</p> <p>Interviews on 05/03/12, conducted at 4:00 PM, with UM #1, at 3:45 PM, with UM #2, at 4:05 PM, with UM #3, and at 5:15 PM, with the SDC revealed they verified that all residents identified to be Full Code status had a yellow wristband in place on 04/25/12.</p> <p>Observations conducted on 05/03/12, from 4:30 PM till 5:00 PM, of the 16 residents on the Third Floor and from 4:00 PM till 5:00 PM, of the 13</p>	F 309		

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F 309	<p>Continued From page 25</p> <p>residents on the Second Floor identified to be Full Code status revealed the residents were wearing yellow wristbands.</p> <p>Observations conducted during the standard survey process from 05/01-03/12, revealed Residents #7, #13, #15, #16, #17, and #18 who were identified to be Full Code status were wearing yellow wristbands.</p> <p>A review of the every 4-hour checks revealed nursing staff checked all residents identified to be Full Code status, to ensure they had a yellow wristband in place beginning on 04/25/12, and continued the every 4-hour checks for the next 72 hours.</p> <p>Record review of the 29 residents identified by the facility to be a Full Code status revealed nursing staff documented on the residents' MAR each shift that the residents' yellow bracelets were in place.</p> <p>Interviews on 05/03/12, at 3:00 PM, with LPN #2, at 3:05 PM, with RN #1, at 3:10 PM, with LPN #7, at 4:00 PM, with UM #1, at 3:15 PM, with RN #7, at 3:25 PM, with LPN #3, at 3:45 PM, with UM #2, and at 4:05 PM, with UM #3 revealed all residents identified as a Full Code were checked every 4 hours for 72 hours and then each shift to ensure the yellow wristbands remained in place. Interview further revealed all Full Code residents were monitored every shift to ensure yellow bracelets were in place and this was documented on the residents' MARs.</p> <p>A review of staff in-services revealed all nursing staff was in-serviced on the Full Code policy</p>	F 309		

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F 309	<p>Continued From page 26</p> <p>revisions to include the placement of yellow wristbands to designate Full Code status which began on 04/25/12, and was completed on 04/26/12, by the Director of Clinical Support Services (DCSS), the DON, the SDC, and the UMs.</p> <p>Interviews on 05/03/12, at 2:30 PM, with the DON, at 3:45 PM, with the DCSS, at 4:00 PM, with UM #1, at 3:45 PM, with UM #2, and at 4:05 PM, with UM #3, revealed in-services regarding the Full Code policy, head to toe assessments of the residents, and actions to take when the resident was assessed to have a change in condition were conducted in person and over the phone on 04/25/12, prior to staff providing care to residents. Licensed staff completed a return demonstration to verify competency of the training.</p> <p>Interviews conducted on 05/03/12, at 3:00 PM, with LPN #2, at 3:05 PM, with RN #1, at 3:10 PM, with LPN #7, at 4:00 PM, with UM #1, at 3:15 PM, with RN #7, at 3:25 PM, with LPN #3, at 3:45 PM, with UM #2, at 4:05 PM, with UM #3 and with CNAs #11, #14, #15, and #16 verified staff had been in-serviced on 04/25/12 and 04/26/12, regarding the procedures for residents who experienced a change of condition and assessment skills. The interviews revealed the staff was tested and performed return demonstrations on the in-service material. The interviews further revealed staff had been in-serviced regarding the change in the facility's Code Status policy and procedures for monitoring placement of the yellow wristband every shift.</p> <p>A review of the in-service/competency checks</p>	F 309		

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F 309	<p>Continued From page 27</p> <p>revealed licensed staff was in-serviced on assessment skills (head to toe assessments, normal versus abnormal assessment findings with focus on heart, lungs, and pupils) and to respond immediately upon any assessed change in a resident's condition on 04/27/12 and 04/28/12, by the DON, the DCSS, the UMs, and the SDC. The facility verified competency by return demonstration on 04/28/12, for each licensed staff person.</p> <p>A review of audits revealed the SDC and or the UMs conducted weekly audits on 04/30/12, 05/01/12, and 05/02/12, of ten staff members to ensure comprehension of the Code Status policy, assessment skills, and actions to take when assessed to have a change in condition. No concerns were found with the audits.</p> <p>A review of the audits of the 24-hour reports revealed the UMs were conducting audits of the 24-hour nursing report five days a week. No concerns were found with the audits.</p> <p>A review revealed the UMs audited the MARs of residents identified to be Full Code status three times weekly on 05/01/12, 05/02/12, and 05/03/12, to ensure licensed staff was monitoring and documenting the yellow wristbands were in place.</p> <p>Interviews on 05/03/12, at 4:00 PM, with UM #1, at 3:45 PM, with UM #2, at 4:05 PM, with UM #3, and at 5:15 PM, with the SDC revealed they will conduct ten nursing staff audits weekly to ensure comprehension of the code status policy, assessment skills and actions to take when a resident is identified with a change in condition.</p>	F 309		
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F 309	<p>Continued From page 28</p> <p>Interview further revealed the 24-hour nursing report would be audited daily five days a week, along with audits of the MARs for residents with Full Code status three times a week, to ensure any resident who experienced a change in condition was assessed to ensure immediate action was taken to address the change in condition.</p> <p>Interview on 05/03/12, at 5:30 PM, with the SDC revealed there had been no new admissions to the facility since 04/29/12. However, a review of an admission sheet revealed documents for the admitting nurse to complete for residents who had chosen Full Code status.</p> <p>Interviews on 05/03/12, at 4:00 PM, with UM #1, at 3:45 PM, with UM #2, and at 4:05 PM, with UM #3 revealed they will check admission paperwork for Code Status, check for the appropriate wristband, and check the MARS for the every shift yellow wristband checks.</p>	F 309		
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record</p>	F 323	<p>F323</p> <ol style="list-style-type: none"> 1. No individual residents were affected by these findings. 2. All residents have the ability to be affected by these findings. 3. The toasters were removed from the dining room areas and placed in a secured area. The dining areas were audited for hazards for the residents on 5/4/2012 by the Administrator. 	

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F 323	<p>Continued From page 29</p> <p>review it was determined the facility failed to ensure the resident environment remained as free of accident hazards as is possible. Toasters were observed on 05/02/12, in resident dining rooms on the second and third floors within reach of residents. A medication cart was left open, unattended, and not in view of the nurse administering medications on the Three North hallway at two separate times during medication administration on 05/02/12.</p> <p>The findings include:</p> <p>1. An interview conducted with the Administrator on 05/03/12, at 8:45 AM, revealed the facility did not have a policy for the storage and use of the toasters in the resident dining rooms.</p> <p>A review of the list of wandering residents provided by the facility revealed six residents on the second floor and eleven residents on the third floor were identified with wandering behavior by the facility.</p> <p>Observations conducted on 05/02/12, at 2:50 PM, revealed a toaster sitting on the counter in the second floor dining room, plugged in and ready for use. Additional observations conducted on 05/02/12, at 7:10 PM, revealed a toaster plugged in and ready for use on top of the ice machine in the third floor dining room. Seven residents were observed sitting in the third floor dining room with no staff members observed providing supervision to residents.</p> <p>An interview conducted with Unit Manager (UM) #1 and UM #2 on 05/03/12, at 9:35 AM and 10:15 AM, revealed the toasters were used to make</p>	F 323	<p>A Policy regarding kitchen appliances in resident accessible areas was written and reviewed by the Administrator and the DCSS on 5/22/12. The Medication Administration General Guidelines Policy and procedure for the storage of medications was reviewed by the Administrator and DCSS on 5/22/12.</p> <p>Kitchen and nursing staff was re- educated by the staff development coordinator and the Administrator on 5/22/2012 and 5/24/2012 on the storage of kitchen appliances.</p> <p>Resident accessible dining areas will be audited 2 times weekly for appliances by the Administrator or Maintenance director for 4 weeks, then weekly for 4 weeks then monthly for 3 months.</p> <p>Licensed staff was educated by the SDC on 5/24/2012 on keeping medication carts locked when out of direct sight of the nurse. Any staff on LOA or unable to attend will be educated prior to working.</p> <p>Medication Carts will be audited by the Unit managers during medication passes 3 times weekly for 4 weeks to ensure they remain locked when out of sight of the nurse, then weekly for three months, then as directed by the QA committee.</p> <p>The Administrator will take the audit results to the Quality Assurance committee monthly and review with Medical director quarterly to ensure continued compliance.</p>	05/30/12
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F 323	<p>Continued From page 30</p> <p>toast for residents and were left unattended in the second and third floor dining rooms but had been sporadically stored in the offices of UM #1 and UM #2. According to UMs #1 and #2, the facility had no policy regarding the use/storage of toasters. Further interviews with the Unit Managers revealed they were not aware of any resident being burned by a toaster at the facility.</p> <p>2. A review of the facility policy titled Medication Administration General Guidelines (undated) revealed during administration of medications the medication carts should be kept closed and locked when out of sight of the medication nurse/aide.</p> <p>Observation of a medication cart on the Three North hallway on 05/02/12, at 8:45 AM, revealed the medication cart was left unlocked and not within sight of the Licensed Practical Nurse (LPN #9).</p> <p>Observation of Medication Administration conducted on 05/02/12, at 9:00 AM, revealed LPN #9 prepared medications for Unsampld Resident A, entered the resident's room to administer medications, and did not close/lock the medication cart. LPN #9 did not keep the medication cart in sight during the administration of medication to Unsampld Resident A.</p> <p>An interview conducted with LPN #9 on 05/02/12, at 9:10 AM, revealed LPN #9 was aware the medication cart was required to be locked when left unattended or out of sight. LPN #9 stated she forgot to close/lock the cart both times when she left the cart to administer medications to residents.</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702
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F 323	Continued From page 31	F 323		
F 363 SS=D	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to serve the correct amount of entree (turkey vegetable pie) for six unsampled resident trays as specified on the menu spreadsheet at the evening meal on 05/01/12. The menu spreadsheet for the evening meal on 05/01/12, specified a regular serving size was eight ounces, and the serving size for a reduced carbohydrate diet was six ounces of the turkey vegetable pie. Observation revealed four ounces were served to the unsampled residents.</p> <p>The findings include: A review of the facility's policy/procedures for standardized portions/pre-portioning (no effective date) revealed portion sizes were written on the</p>	F 363	<p>F363</p> <ol style="list-style-type: none"> 1. Individual residents were not identified. 2. All residents have the ability to be affected by this practice. 3. Dietary manager was re-educated by the dietitian on 5/22/2012 to post the menu spreadsheet in the preparation and service area. The dietary staff including the dietary manager was re-educated by the dietitian on May 22, 2012 on the difference between an 8 ounce ladle and a number eight scoop. This education did include the necessity for using a required ladle or scoop size as designated on the preparation spreadsheet when preparing portions for the resident's trays. The dietitian will audit the tray line one time weekly for 4 weeks, then 2 times monthly for two months, then monthly for 3 months for the use of the proper sized ladles or scoops for portion control and the posting of the menu spreadsheet. 	

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F 363	<p>Continued From page 32</p> <p>menu to ensure equal portions were served in order to provide adequate nutritional care, and proper portion control equipment would be used for serving foods. Further review of the policy/procedure revealed established serving portions should be posted in the preparation and service area.</p> <p>Observation of the evening meal at 4:45 PM on 05/01/12, revealed the main entree was turkey vegetable pie. According to the menu spreadsheet, 8 ounces was the amount to be served. Further observation of the tray line revealed the cook served six servings of the turkey vegetable pie with a #8 scoop which was equal to 4 ounces of the main entree. Further observation revealed the menu spreadsheet was not posted in the preparation and service area as noted in the standardized portions/pre-portions policy/procedure.</p> <p>An interview was conducted with the cook at 4:55 PM on 05/01/12. The cook stated regular servings should be served with a #8 scoop (equal to 4 ounces) for all the residents except residents who were on a reduced carbohydrate diet, and those residents were served with a 6-ounce ladle. In addition, the Dietary Manager confirmed the menu spreadsheet was not posted.</p> <p>A review of the menu spreadsheet for the evening meal on 05/01/12, revealed a serving size for turkey vegetable pie for a regular diet was an 8-ounce ladle, pureed diet was two #8 scoops (equal to 8 ounces), and the reduced carbohydrate diet was a 6-ounce ladle.</p> <p>A review of the equivalent serving utensil sizes</p>	F 363	<p>4. These audits will be presented to the Administrator as well as any other findings in the kitchen. The Administrator will take the audit results to the Quality Assurance committee monthly and review with Medical director quarterly to ensure continued compliance.</p>	05/30/12

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F 363	Continued From page 33 revealed a #8 scoop was equal to 4 ounces, a 6-ounce ladle was equal to 6 ounces, and an 8-ounce ladle was equal to 8 ounces.	F 363		
F 386 SS=D	<p>483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS</p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy, it was determined the facility failed to ensure physician's orders were signed and dated for two of twenty-one sampled residents. Residents #6 and #13 had monthly and telephone orders which were not signed and dated by the physician.</p> <p>The findings include:</p> <p>A review of the Physicians Orders Policy (no date) revealed Medical Records staff was responsible to mail or hand deliver any unsigned physician's orders to the appropriate physician. The policy stated the physician was responsible to return the signed/dated physician's orders to the facility within ten days and the signed orders were to be placed on the resident's medical record.</p>	F 386	<p>F386</p> <ol style="list-style-type: none"> 1. Resident # 6- The chart was audited for unsigned telephone orders by the medical records manager on May 22, 2012. Missing signed physicians orders were placed upon the chart on May 22, 2012. Resident # 13 chart was audited for unsigned telephone and admission orders by the medical records manager on May 22, 2012. The signed admission orders and telephone orders were placed on the chart on May 23, 2012. 2. All residents have the ability to be affected by this practice. 3. Resident's charts were reviewed for missing signed telephone orders on May22, 2012 by medical records staff. Signed telephone orders that were obtained were placed on the resident records. Physicians that were found to have outstanding telephone orders were sent a letter requesting them to return orders to the facility. The medical records manager was educated by the DCSS on May 15, 2012 related to medical records 	

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F 386	<p>Continued From page 34</p> <p>1. A review of the medical record for Resident #6 revealed the facility admitted the resident on 12/04/09, with diagnoses of Seizures, Dementia, Organic Mental Syndrome, Blindness, and Hearing Loss. A review of the medical record revealed the attending physician visited Resident #6 at the facility on 03/14/12; however, none of the physician's telephone orders after 02/11/12, had been signed by the attending physician.</p> <p>Interview with Medical Records (MR) Manager on 05/03/12, at 1:50 PM, revealed the physician's orders were mailed to the appropriate physician each Monday and Friday. The MR Manager stated the orders were usually returned to the facility within a week. The MR Manager stated she overlooked the telephone orders for Resident #6 and had failed to obtain the physician's signature.</p> <p>2. A review of the medical record for Resident #13 revealed the facility admitted the resident on 03/30/12, with diagnoses of Status post left shoulder fracture with Open Reduction Internal Fixation (ORIF), Osteoporosis, Carotid Artery Stenosis, Diabetes Mellitus, and Hypertension. A review of the medical record revealed the attending physician visited Resident #13 at the facility on 04/04/12, 04/11/12, 04/18/12, and 04/25/12; however, the admission physician's orders were not signed by the attending physician.</p> <p>Interview with Unit Manager (UM) #2 on 05/02/12, at 7:20 PM, revealed MR staff was responsible to mail or hand deliver the physician's orders to the physician to be signed. UM #2 stated the</p>	F 386	<p>practices and expectations. Telephone orders tracking system that requires a copy of the unsigned physician's order be kept until the original has been returned to the facility was initiated on May 23, 2012. Any physicians not returning telephone orders to the facility timely will be contacted by administrative staff. The infection control nurse or DON will audit 10 charts weekly for signed physicians orders and admission orders for four weeks, then five charts weekly for four weeks, then as recommended by the quality assurance committee. The Director of Nursing will audit the order tracking system weekly for 4 weeks, then once every two weeks for two months, then monthly for three months.</p> <p>4. The Administrator will take the audit results to the Quality Assurance committee monthly and review with Medical director quarterly to ensure continued compliance.</p>	05/30/12

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F 386	Continued From page 35 physician was also responsible to sign the orders when the physician made visits to see the resident. UM #2 further stated she was responsible to check the resident's medical record to ensure the physician's orders were signed and dated. The UM stated she had not identified that physician's orders were not signed because she believed the MD had signed the orders during visits to the facility. Interview with the MR Manager on 05/03/12, at 1:50 PM, revealed the physician's orders were mailed to the appropriate physician each Monday and Friday. The MR Manager stated the orders were usually returned to the facility within a week. The MR Manager stated she believed Resident #13's physician's orders had been sent to the physician, but she did not maintain a record to track when the physician's orders were mailed/delivered/returned and could not verify the information.	F 386		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility policies and review of the American Heart Association Manual for Basic Life Support 2010, it was determined the facility failed to be	F 490	F490 1. Resident #1 has expired. 2. All resident can be affected. On April 25, 2012 all residents had their charts audited to ensure physicians orders for current code status and care plans reflected the current code status by the unit managers and staff development coordinator. On April 25, 2012 a licensed nurse began rounds to ensure no residents were in any acute cardiac or respiratory distress and a C.N.A continued to make 30 minute rounds until all	

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F 490	<p>Continued From page 36</p> <p>administered in a manner that enabled resources to be used effectively and efficiently to ensure residents' highest practicable physical, mental, and psychosocial well-being was attained or maintained. The facility's Administration failed to have an effective system to ensure staff assessed residents and responded timely to residents in respiratory arrest per the American Heart Association (AHA), Basic Life Support (BLS) for Healthcare Providers, Guidelines for CPR 2010. An abbreviated standard survey conducted at the facility on 03/02-11/11 resulted in deficient practice due to the facility's failure to administer CPR to a resident who was found to be unresponsive and was a Full Code. The facility's Plan of Correction (POC) dated 03/25/11, stated staff had been trained on what actions to take for residents who were a Full Code, and stated Mock Codes would be conducted to ensure staff followed the facility's policy/guidelines. The facility was conducting Mock Codes quarterly, but failed to monitor to ensure staff assessed residents and responded timely when residents were in respiratory arrest per the American Heart Association CPR Guidelines.</p> <p>On 04/18/12, Resident #1 experienced a change of condition, when family members informed LPN #1 that Resident #1 had quit breathing, while LPN #1 and family members were in the room. LPN #1 did not assess the resident, and left the room to go to the nurses' desk to obtain the resident's code status prior to the resident receiving emergency medical care by staff. A review of nursing notes revealed Resident #1 experienced "shallow" respirations at 5:35 PM, and the nursing notes stated 911 was notified and CPR was</p>	F 490	<p>residents that were full code status had a yellow wristbands in place. On April 25, 2012 a licensed nurse completed a cardio/pulmonary assessment on all residents. On April 25, 2012 the unit manager or staff development coordinator placed a yellow wristband on the arm of all residents with a verified full code status. A physician's order was obtained on April 28, 2012, for nurses to check residents who were a full code for a yellow wristband placement each shift. Beginning April 25, 2012 the licensed nurse checked all residents with yellow wristband every shift to ensure the wristband remained in place, and documents on the residents medication administration record, indicating the yellow bracelet was in place.</p> <p>3. Beginning on April 25, 2012 all nursing staff was re-educated on revised code status policy and procedure that included the placement of yellow wristbands to designate full code status, by the DCSS, the DON, the SDC, and the UM's. The re-education included the necessity for immediate action by the nurse when upon assessment a resident was found to have a change in condition. This education was completed in person and by telephone prior to any nurse caring for the resident and</p>	

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F 490	<p>Continued From page 37</p> <p>started at 5:40 PM. Based on a review of the ambulance report 911 was contacted at 5:38 PM, approximately three minutes, per nursing notes and interview, after Resident #1 experienced a change in condition and stopped breathing. Resident #1 was transported to the local Emergency Room where the resident was pronounced dead at 6:22 PM (refer to F309 and F520).</p> <p>The facility's failure to have an effective system in place to provide timely care and services for Resident #1, who experienced a change in condition, and failure to implement action plans to correct quality deficiencies, placed Resident #1 and other residents at risk for serious injury, harm, impairment, or death.</p> <p>An Allegation of Compliance (AOC) was received on 04/30/12, which alleged removal of Immediate Jeopardy on 04/29/12. The State Agency determined the Immediate Jeopardy was removed on 04/29/12, as alleged, which lowered the scope and severity to "D" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Plan of Correction (POC) dated 03/25/11, revealed nursing staff was to receive ongoing in-service training by the Staff Development Coordinator (SDC) regarding the guidelines for determining if a resident was a Full Code, how to promptly identify each resident's code status, and what actions to take if the resident was a Full Code. The POC stated the Director of Nursing (DON), Assistant Director of</p>	F 490	<p>completed on April 26, 2012. The staff competency was insured by having them verbalize the change in this policy. On April 28, 2012 the DON the DCSS, UM's and the SDC re-educated all licensed staff on assessment skills and verified competency with return demonstration. The education did include;</p> <p>(a) Head to toe assessments. (b)The assessment focused on the primary organs such as heart, lungs, and pupils and how to properly assess each, along with normal findings and abnormal findings on assessment.</p> <p>On April 27, 2012 the DON, the SDC, and the UM's re-educated the nurses to respond and act immediately upon an assessed change of condition in the resident status.</p> <p>All new nursing staff will be educated and tested through return demonstration on their assessment skills, code status, and actions to take when the resident is assessed to have a change in condition prior to caring for resident. The new staff will be required to complete a posttest to ensure comprehension of the policies.</p>	

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F 490	<p>Continued From page 38</p> <p>Nursing (ADON), and Unit Managers (UMs) would conduct mock codes on diverse shifts to ensure staff followed the facility's policy/guidelines for Full Code residents. The POC further stated the Administrator would review all audit findings and report to the QA Committee monthly, and then review the findings with the Medical Director at the quarterly QA meetings to evaluate the effectiveness of the actions taken.</p> <p>A review of the facility's policy, "Changes of Condition," dated 02/01/12, revealed it was the goal of the facility for a licensed nurse to do a thorough assessment on each resident as their condition changed and to notify the resident, responsible party, and physician.</p> <p>A review of the facility's "Full Code Status verses No Code-DNR" policy, not dated, revealed if a resident did not have a "no code-DNR" physician's order the resident was considered to be a "Full Code." Upon finding the resident with no pulse and not breathing a full code was required to be initiated with chest compression and breaths, and 911 was to be called immediately.</p> <p>A review of the facility's policy, "Guidelines To Take in a Full Code Situation," dated 03/03/11, revealed the first nurse responder was to verify code status, by checking the resident's medical record to ensure the resident was a Full Code and then was to direct the actions of other staff.</p> <p>A review of the American Heart Association (AHA), Basic Life Support (BLS) for Healthcare Providers, Guidelines for CPR 2010, revealed a</p>	F 490	<p>The VP of Older Adult Communities reviewed and re-educated the Administrator in regards to the essential functions of his job description on 5/23/12.</p> <p>The admitting nurse will place a yellow wristband on the wrist of all residents admitted to the facilities that choose a full code status.</p> <p>The SDC and/or UM's will audit ten Nursing staff members weekly to ensure comprehension of the code status policy, assessment skills, and actions to take when a resident is identified with a change in condition for 4 weeks, then 5 Nursing staff members per week for 4 weeks, then as recommended by the QA committee. The UM will audit the 24-hour nursing report for assessment findings as well as what immediate actions were taken, based upon the assessment findings, to care for the resident with a change of condition 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks then as recommended by the Quality Assurance Committee.</p> <p>The DON will review the UM's audits and will present the findings to the Administrator. UM's will audit the MAR's of the residents that have chosen a full code status three times weekly to ensure licensed nurses have completed the required yellow</p>	

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F 490	<p>Continued From page 39</p> <p>critical concept for high quality CPR was to start compressions within ten seconds of recognition of cardiac arrest. According to the AHA, the first step for adults was to assess the victim for response and look for normal or abnormal breathing. If there was no response and no breathing or no normal breathing, shout for help. The healthcare provider should not delay activating the emergency response system but should check the victim simultaneously for response and breathing. The rescuer should activate the emergency response system and begin CPR if the adult victim was unresponsive and not breathing or not breathing normally and had no pulse. If within ten seconds, no pulse was found or if the rescuer was not sure of a pulse, begin chest compression.</p> <p>Interview with the Director of Nursing (DON) on 04/26/12, at 5:25 PM, revealed LPN #1 followed the facility's policy by leaving the room when the resident ceased to breathe on 04/18/12. The DON further stated according to facility policy the nurse was to always look at the resident's medical record to verify the resident's code status prior to initiating resuscitative measures.</p> <p>Further interview with the DON on 04/27/12, at 4:38 PM, revealed facility staff had been performing mock codes weekly for three months, then one time a month, and facility staff was "doing good" so the mock codes were conducted quarterly. The DON stated the mock code consisted of a fake resident (staff member) placing a sign on their body that would inform staff what was wrong with them such as "no heartbeat," "no breathing." Facility staff, after finding the fake resident was then required to go</p>	F 490	<p>wristband checks for 4 weeks, then weekly for 4 weeks, then monthly or as recommended by the QA Committee. The Administrator will review the UM's MAR audits to ensure completeness and present the findings to the quarterly quality assurance meetings. The UM will check all newly admitted resident admission paperwork for the selected code status. They will also check the resident for the appropriate wristband, and check the MAR to ensure the wristband checks are documented on the MAR.</p> <p>A Mock Code as outlined in guidelines to take in a full code situation (see exhibit A) that includes the response time of the staff to begin treatment will be run monthly for 6 months then quarterly.</p> <p>The Administrator will take the audit results and Mock Code results including time of response to the Quality Assurance committee monthly and review with Medical director quarterly to ensure continued compliance.</p>	05/30/12
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2012
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702
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F 490	<p>Continued From page 40</p> <p>to the nurses' desk where a mock code folder was placed that had the code status for the fake resident. If the fake resident was a Full Code then staff was required to page a "code" over the intercom and begin giving directions for other staff such as start CPR, get the crash cart, or hold the elevator. The DON further stated facility staff had been "doing good" during the mock codes and also felt facility staff "did good" on the night of 04/18/12, when Resident #1 experienced a change in condition. Further interview with the DON revealed facility staff had not identified a problem with the length of time it took to begin CPR, due to the fact the mock codes had never been timed to identify how long it took staff to find the resident, check the resident's code status, and begin emergency medical interventions if needed. The DON further stated assessments such as listening to lungs for breathing or the chest for a heartbeat were never incorporated into the mock code drills, therefore no problems had been identified.</p> <p>Interview with the Administrator, on 05/03/12, at 4:00 PM, revealed he observed the first mock code and then reviewed the audits of the mock codes conducted by the DON. The Administrator stated during the review of the audits the facility's QA Committee had not identified any issue with a time lapse in CPR initiation.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 04/30/12, which alleged removal of IJ effective 04/29/12. A standard health/extended survey was conducted on 05/01-03/12, which determined the IJ was removed on 04/29/12 as alleged.</p>	F 490		

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F 490	<p>Continued From page 41</p> <p>--A review of the AOC revealed the following:</p> <p>On 04/25/12, the Administrator and Director of Nursing (DON) reviewed and revised the facility's Code Status policy to include the utilization of yellow wristbands to designate Full Code status for residents.</p> <p>On 04/26/12, the Medical Director reviewed and approved the revised Code Status policy.</p> <p>The DON will review the UMs' audits and will present the findings at the quarterly Quality Assurance (QA) meetings.</p> <p>The Administrator will review the UMs' MARs audits to ensure completeness and present the findings at the quarterly QA meetings.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Review of the Code Status policy revealed the policy was revised to include the utilization of a yellow wristband to designate Full Code status, which was approved and signed by the Medical Director on 04/26/12.</p> <p>Interviews on 05/03/12, at 4:00 PM, with the Administrator and at 2:30 PM, with the DON, revealed the Vice President of Operations, the Nurse Consultant, the Medical Director, the Administrator, the DON, and the SDC met and discussed changes that needed to be made to the facility's Code Status policy on 04/25/12. The interviews revealed after the group agreed on the changes that were required, the policy was</p>	F 490		

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F 490	Continued From page 42 revised, and the Medical Director reviewed and signed the revised Code Status policy on 04/26/12.	F 490		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to obtain laboratory services as ordered by the physician for three of twenty-one residents (Residents #9, #11, and #18). The findings include: A review of the facility's Lab Services policy/procedure (no date) revealed the lab order was to be placed on a calendar at the nurses' station and the third shift nurse would be responsible to complete the lab requisition form for the lab draw due the following day. The policy stated the third shift nurse would obtain the lab specimen and indicate on the calendar that the lab had been obtained. The policy further stated the physician, family, and the resident would be notified when the results of the lab was returned to the facility. 1. A review of the medical record revealed the facility admitted Resident #11 on 05/13/11, with diagnoses to include Coronary Artery Anomaly, Hyperlipidemia, Hypertension, Atrial Fibrillation,	F 502	F502 1. Residents # 9 and # 11, had their lab orders reviewed and new physicians orders obtained. The lab orders residents for residents # 9 and # 11 are now accurate and current. Resident # 16 has discharged. 2. All current residents Lab orders were reviewed and are accurate. 3. All residents' charts were reviewed for lab orders by licensed nurses on May 21, 2012. New physician's orders for labs were obtained and scheduled as ordered. The lab policy and procedure (see exhibit B) was reviewed and revised by the director of clinical support services and the Administrator on May 22, 2012. The lab policy and procedure was reviewed and approved by the medical director on May 24, 2012. Licensed nurses were educated on the changed lab policy and procedure on May 24, 2012 by the staff development coordinator. Unit managers will audit 50% of labs ordered and obtained three times weekly to ensure the labs ordered have been placed on the lab calendar on the date ordered, labs ordered for the previous day were completed, returned, MD notified, orders obtained if required and the resident and family notified of any new orders obtained for accuracy for four weeks, then weekly for four weeks, then	

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F 502	<p>Continued From page 43</p> <p>Coronary Artery Disease, and Hypothyroidism. A review of the May 2012 physician's orders revealed a Complete Blood Count (CBC) was to be obtained monthly. A review of the lab reports revealed the most recent CBC was obtained on 03/03/12. There was no evidence the facility had obtained the CBC due in April 2012 for Resident #11.</p> <p>Interview with Unit Manager (UM) #3 on 05/02/12, at 3:25 PM, revealed she was responsible for placing the lab orders on the calendar each month and the night shift nurse was responsible for completing the lab requisition and obtaining the lab specimen. The UM stated she was on vacation when the CBC for Resident #11 should have been done and did not know who was responsible for ensuring the lab was put on the calendar to be drawn in her absence.</p> <p>2. A review of the medical record revealed the facility admitted Resident #9 on 07/06/10, with diagnoses to include Anemia, Hypertension, Frequent urinary Tract Infections, Congestive Heart Failure, Peripheral Vascular Disease, and Hypocalcemia. A review of the current physician's orders dated 04/01/12, revealed a Basic Metabolic Panel (BMP) and a CBC was to be obtained every six months (January and July).</p> <p>There was no evidence the facility obtained the BMP or CBC as ordered in January 2012. A review of the lab reports revealed the BMP and the CBC were not obtained until the attending physician ordered a Comprehensive Metabolic Panel (CMP) and a CBC on 04/11/12.</p> <p>Interview with UM #3 on 05/03/12, at 10:40 AM,</p>	F 502	<p>monthly for three months, then as recommended by the quality assurance committee.</p> <p>4. These audits that include the labs ordered that have been placed on the lab calendar on the date ordered, labs ordered for the previous day were completed, returned MD notified, orders obtained if required and the resident and family notified of any new orders obtained will be presented to the Director of Nursing for review. The DON will review these audit findings with the Administrator. The Administrator will take the audit results to the Quality Assurance committee monthly and review with Medical director quarterly to ensure continued compliance.</p>	05/30/12

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F 502	<p>Continued From page 44</p> <p>revealed the BMP and CBC were scheduled to be obtained on 01/18/12. However, the person who wrote the labs on the calendar for that date wrote Potassium (K+) out from the resident's name and the BMP and CBC were written above the resident's name. The nurse who obtained the lab for Resident #9 did not realize the BMP and CBC were for this resident; therefore, the labs were not obtained.</p> <p>3. A review of the medical record revealed the facility admitted Resident #18 on 08/30/07, with diagnoses to include Hypothyroidism, Metabolic Disease, Deep Vein Thrombosis, Dysphagia, Abnormal Serum Chemistry Tests, and Abnormal Glucose Tolerance Test. A review of the current physician's orders dated 04/01/12, revealed a Complete Blood Count (CBC) was to be obtained monthly for Resident #18. A review of the lab reports revealed the CBC was not obtained in April 2012 as ordered by the physician for Resident #18.</p> <p>Interview with UM #3 on 05/03/12, at 10:45 AM, revealed a Total triiodothyronine 3 (T3) was placed on the calendar for the month of April, however, the monthly CBC was not. Therefore, the CBC was not obtained for Resident #18 for the month of April 2012.</p>	F 502		
F 520 SS=J	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the</p>	F 520	<p>F520</p> <ol style="list-style-type: none"> Resident #1 has expired. Residents # 20 and #21 have shown no negative outcome from the unsubstantiated allegations. All resident can be affected. On April 25, 	

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F 520	<p>Continued From page 45 facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, policy review, review of a Statement of Deficiencies (SOD) dated 03/08/11, and review of the facility's Plan of Correction (POC) dated 03/25/11, it was determined the facility failed to have an effective system to identify issues for which quality assessment and assurance activities were necessary, and failed to develop and implement appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to provide care/services and the facility's failure to implement its Abuse Reporting & Prevention policy.</p> <p>The facility failed to ensure staff assessed one of</p>	F 520	<p>2012 all residents had their charts audited to ensure physicians orders for current code status and care plans reflected the current code status by the unit managers and staff development coordinator. On April 25, 2012 a licensed nurse began rounds to ensure no residents were in any acute cardiac or respiratory distress and a C.N.A continued to make 30 minute rounds until all residents that were full code status had a yellow wristbands in place. On April 25, 2012 a licensed nurse completed a cardio/pulmonary assessment on all residents. On April 25, 2012 the unit manager or staff development coordinator placed a yellow wristband on the arm of all residents with a verified full code status. A physician's order was obtained on April 28, 2012, for nurses to check residents who were a full code for a yellow wristband placement each shift. Beginning on April 25, 2012 the licensed nurse checked all residents with yellow wristband every shift to ensure the wristband remained in place, and documents on the residents medication administration record, indicating the yellow bracelet was in place.</p> <p>All residents have the potential to be affected by acts of abuse and/or neglect. The staff does report suspected issues immediately to their supervisor, who immediately reports these allegations to the Administrator. All allegations will continue to be investigated immediately.</p> <p>3. Beginning on April 25, 2012 all nursing</p>	

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F 520	<p>Continued From page 46</p> <p>twenty-one residents (Resident #1) when the resident experienced a change of condition and failed to ensure staff immediately initiated emergency medical care when the resident stopped breathing. On 04/18/12, family members noted a change in Resident #1's condition and summoned Licensed Practical Nurse (LPN) #1 to the resident's room. At 5:35 PM, while LPN #1 was in the resident's room, the family reported to the nurse Resident #1 had stopped breathing. LPN #1 left Resident #1's room to check the resident's code status without first assessing the resident's condition and initiating emergency care as needed. According to documentation from the ambulance service, 911 was called at 5:38 PM on 04/18/12, three minutes after Resident #1 experienced the change of condition. Nursing notes revealed staff did not start Cardiopulmonary Resuscitation (CPR) until 5:40 PM, approximately five minutes after Resident #1 experienced a change of condition. Resident #1 was pronounced dead upon arrival to the Emergency Room at 6:22 PM.</p> <p>The facility also failed to ensure two abuse allegations reported by Resident #2 and Resident #20 were reported to the appropriate state agencies as per the facility Abuse Reporting & Prevention policy.</p> <p>The facility's failure to have an effective system to ensure the Quality Assurance Program identified and implemented appropriate plans of action to correct identified quality deficiencies placed Resident #1 and other residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 04/25/12, and was determined to exist on</p>	F 520	<p>staff was re-educated on revised code status policy and procedure that included the placement of yellow wristbands to designate full code status, by the DCSS, the DON, the SDC, and the UM's. The re-education included the necessity for immediate action by the nurse when upon assessment a resident was found to have a change in condition. This education was completed in person and by telephone prior to any nurse caring for the resident and completed on April 26, 2012. The staff competency was insured by having them verbalize the change in this policy. On April 28, 2012 the DON, the DCSS, UM's and the SDC reeducated all licensed staff on assessment skills and verified competency with return demonstration. The education did include;</p> <p>(a) Head to toe assessments. (b) The assessment focused on the primary organs such as heart, lungs, and pupils and how to properly assess each, along with normal findings and abnormal findings on assessment.</p> <p>On April 27, 2012 the DON, the SDC, and the UM's re-educated the nurses to respond and act immediately upon an assessed change of condition in the resident status.</p>	

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F 520	<p>Continued From page 47 04/18/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/30/12, with the facility alleging removal of the Immediate Jeopardy on 04/29/12. Immediate Jeopardy was verified to be removed on 04/29/12, as alleged prior to exiting with the facility on 05/03/12, which lowered the scope and severity to "D" while the facility develops and implements a Plan of Correction, and monitors the effectiveness of the systemic changes and Quality Assurance activities.</p> <p>The findings include:</p> <p>1. A review of an SOD dated 03/08/11, revealed an abbreviated standard survey was conducted on 03/02-11/11, which resulted in deficient practice due to the facility's failure to administer Cardiopulmonary Resuscitation (CPR) to a resident who was found to be unresponsive and was a Full Code.</p> <p>A review of the facility's Plan of Correction (POC) dated 03/25/11, revealed nursing staff would receive ongoing in-services by the Staff Development Coordinator (SDC) regarding the guidelines for determining if a resident was a Full Code, how to promptly identify each resident's code status, and what actions to take if the resident was a Full Code. The POC stated the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers (UMs) would conduct mock codes on diverse shifts to ensure staff followed the facility's policy/guidelines for Full Code residents. The POC further stated the Administrator would</p>	F 520	<p>All new nursing staff will be educated and tested through return demonstration on their assessment skills, code status, and actions to take the resident is assessed to have a change in condition prior to caring for resident. The new staff will be required to complete a posttest to ensure comprehension of the policies.</p> <p>The admitting nurse will place a yellow wristband on the wrist of all residents admitted to the facilities that choose a full code status.</p> <p>The SDC and/or UM's will audit ten Nursing staff members weekly to ensure comprehension of the code status policy, assessment skills, and actions to take when a resident is identified with a change in condition for 4 weeks, then 5 Nursing staff members per week for 4 weeks, then as recommended by the QA committee. The UM will audit the 24-hour nursing report for assessment findings as well as what immediate actions were taken, based upon the assessment findings, to care for the resident with a change of condition 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks then as recommended by the Quality Assurance Committee.</p> <p>The DON will review the UM's audits and will present the findings to the</p>	

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F 520	<p>Continued From page 48</p> <p>review all audit findings and report to the Quality Assurance (QA) Committee monthly, and then review the findings with the Medical Director at the quarterly QA meetings to evaluate the effectiveness of the actions taken.</p> <p>A review of the facility's "Full Code Status verses No Code-DNR" policy, not dated, revealed if a resident did not have a "no code-DNR" physician's order, the resident was considered to be a "Full Code." The policy stated upon finding the resident with no pulse and not breathing, a Full Code was required to be initiated with chest compression and breaths, and 911 was to be called immediately.</p> <p>A review of the facility's policy, "Guidelines To Take in a Full Code Situation," dated 03/03/11, revealed the first nurse responder was to verify code status, by checking the resident's medical record to ensure the resident was a Full Code and then was to direct the actions of other staff.</p> <p>A review of the American Heart Association (AHA), Basic Life Support (BLS) for Healthcare Providers, Guidelines for CPR 2010, revealed a critical concept for high quality CPR was to start compressions within ten seconds of recognition of cardiac arrest. According to the AHA, the first step for adults was to assess the victim for response and look for normal or abnormal breathing. If there was no response and no breathing or no normal breathing, shout for help. The healthcare provider should not delay activating the emergency response system but should check the victim simultaneously for response and breathing. The rescuer should activate the emergency response system and</p>	F 520	<p>Administrator. UM's will audit the MAR's of the residents that have chosen a full code status three times weekly to ensure licensed nurses have completed the required yellow wristband checks for 4 weeks, then weekly for 4 weeks, then monthly or as recommended by the QA Committee. The Administrator will review the UM's MAR audits to ensure completeness and present the findings to the quarterly quality assurance meetings. The UM will check all newly admitted resident admission paperwork for the selected code status. They will also check the resident for the appropriate wristband, and check the MAR to ensure the wristband checks are documented on the MAR.</p> <p>A Mock Code as outlined in the guidelines to take in a full code situation (see exhibit A) that includes the response time of the staff to begin treatment will be run monthly for 6 months then quarterly.</p> <p>The Administrator will take the audit results and Mock Code results including time of response to the Quality Assurance committee monthly and review with Medical director quarterly to ensure continued compliance.</p> <p>The Quality Assurance program was reviewed by the Director of Clinical Support Services May 18, 2012. The Action Plan format and follow through</p>	

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F 520	<p>Continued From page 49</p> <p>begin CPR if the adult victim was unresponsive and not breathing or not breathing normally and had no pulse. If within ten seconds no pulse was found or if the rescuer was not sure of a pulse, begin chest compressions.</p> <p>On 04/18/12, family members were visiting Resident #1, and when they noticed a change in the resident's condition they summoned the nurse. At 5:35 PM, while Licensed Practical Nurse (LPN) #1 was in the resident's room, family members stated Resident #1 stopped breathing. LPN #1 proceeded to leave the resident's room, to obtain the resident's medical record to verify code status, without assessing the resident's condition and/or initiating any immediate emergency care. According to the ambulance transfer report, facility staff contacted 911 at 5:38 PM, three minutes after the resident experienced a change in condition. Interview with LPN #1 and review of nursing notes revealed facility staff initiated CPR on the resident at 5:40 PM. Resident #1 was transported to the hospital by the ambulance service where the resident was pronounced dead on arrival at 6:22 PM.</p> <p>Interview with the DON on 05/03/12, at 2:30 PM, revealed the mock codes were not timed by the staff conducting the mock code, the staff responding to the code did not document the time the person was identified not to be breathing, the time the Emergency Medical System was activated, or the time the code was initiated or ended. The DON stated she had not identified a lapse in timely CPR initiation while conducting the mock codes; therefore, the facility had not identified or revised their plan of action.</p>	F 520	<p>was revised.</p> <p>The Director of Clinical Support Services will review the Quality Assurance Committee action plans of the facility monthly for 6 months then quarterly for 2 subsequent quarters to ensure the proper use of the action plan to guide the facility in improving its practices. Any re-education needed will be reviewed with the Medical Director at the quarterly Quality Assurance Committee Meeting.</p> <p>The VP of Older Adults did re-educate the Administrator on the reporting requirements of all allegation prior to investigation as found in the Abuse Reporting and Prevention Policy on 5/23/2012.</p> <p>The Administrator will log all allegations on the Abuse/ Neglect reporting log that includes the time and date of the initial report to the Administrator, OIG, APS and law enforcement. The VPOA will review the log that includes the time and date of the initial report to the Administrator, OIG, APS and law enforcement monthly, beginning May 23, 2012 for 6 months and continuing for 2 subsequent quarters.</p> <p>The Administrator will review the logs with the Medical Director quarterly for time and date of the initial report to the Administrator, OIG, APS and law enforcement at</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2012
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702
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F 520	<p>Continued From page 50</p> <p>Interview with the Medical Director on 04/25/12, at 2:50 PM, revealed the facility's Immediate Jeopardy that was identified on 03/08/11, was discussed at the first QA meeting after the Jeopardy was identified. However, the Immediate Jeopardy had not been discussed at a QA meeting he had been involved in since the first meeting. The Medical Director stated facility staff informed him that "everything" "is being done" in relation to the Jeopardy identified on 03/08/11.</p> <p>Interview with the Administrator on 05/03/12, at 4:00 PM, revealed he observed the first mock code and then reviewed the audits of the mock codes conducted by the DON. The Administrator stated during the review of the audits the facility's QA Committee had not identified any issue with a time lapse in CPR initiation (refer to F309).</p> <p>2. A review of an SOD dated 03/08/11, revealed an abbreviated survey conducted on 03/02-11/11, identified deficient practice related to the facility's failure to report possible neglect.</p> <p>Review of the facility's POC dated 03/25/11, revealed nursing staff would receive ongoing in-services by the SDC regarding abuse/neglect prevention and reporting. The POC stated the Administrator and DON were re-in-serviced on identification/investigation of abuse/neglect as well as their duty to report suspected abuse/neglect to the appropriate agencies timely. The POC revealed the DON, ADON, and UM would conduct visual audits of nine residents to ensure there were no indicators of abuse/neglect. The POC further stated the Administrator would review all audit findings and report to the QA</p>	F 520	the Quality Assurance Committee meetings for 4 quarters.	05/30/12

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F 520	<p>Continued From page 51</p> <p>Committee monthly, and then review the findings with the Medical Director at the quarterly QA meetings to evaluate the effectiveness of the actions taken.</p> <p>Review of the facility's Abuse Reporting & Prevention policy, updated July 2001, revealed the Administrator, or designee, will immediately report any incident of abuse/neglect to the appropriate state agencies.</p> <p>Review of the facility's investigation dated 03/04/12, revealed Resident #2 reported that Resident #15 raped Resident #21 during the night of 03/03/12. The investigation stated "Administrator and Director of Nursing (DON) discussed the concern via telephone and it was decided that the information obtained thus far was not criminal in nature and did not need to be reported in two hours."</p> <p>Review of the facility's investigation dated 04/07/12, revealed Resident #20 reported a staff person put their finger in the resident's rectum and the resident started bleeding.</p> <p>Interview with the DON on 05/03/12, at 2:30 PM, revealed after investigating Resident #2's and Resident #20's allegations, there was nothing to report to the State Agencies. The DON stated the facility monitored for resident abuse/neglect but had not monitored for the reporting of allegations of abuse/neglect as part of the QA program.</p> <p>Interview with the Administrator on 05/03/12, at 4:00 PM, revealed he made the decision not to report Resident #2's and Resident #20's allegations to the appropriate state agencies.</p>	F 520		

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F 520	<p>Continued From page 52</p> <p>The Administrator stated the facility monitored for resident abuse/neglect but had not monitored to ensure allegations of abuse/neglect were reported to state agencies (refer to F226).</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 04/30/12, which alleged removal of IJ effective 04/29/12. A standard health/extended survey was conducted on 05/01-03/12, which determined the IJ was removed on 04/29/12, as alleged.</p> <p>--A review of the AOC revealed the following:</p> <p>Beginning on 04/25/12, nursing staff checked all residents with yellow wristbands every four hours to ensure the wristband remained in place. The 4-hour checks continued for the next 72 hours. Then a licensed nurse checked all residents with yellow wristbands every shift to ensure the wristband remained in place, and documented on the resident's Medication Administration Record (MAR), indicating the yellow bracelet was in place. These checks will be ongoing.</p> <p>The SDC and/or UMs will audit ten nursing staff members weekly to ensure comprehension of the Code Status policy, assessment skills, and actions to take when a resident has a change in condition.</p> <p>The UMs will audit the 24-hour nursing report five days a week for assessment findings as well as what immediate actions were taken, based upon assessment findings to care for the resident with changes.</p>	F 520		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702
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F 520	<p>Continued From page 53</p> <p>The DON will review the UMs' audits and will present the findings at the quarterly Quality Assurance (QA) meetings.</p> <p>The UMs will audit the Medication Administration Records (MARs) of the residents that have chosen a Full Code status three times weekly to ensure the licensed nurses have completed the required yellow wristband checks.</p> <p>The Administrator will review the UMs' MARs audits to ensure completeness and present the findings at the quarterly QA meetings.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interviews on 05/03/12, at 3:00 PM, with Licensed Practical Nurse (LPN) #2, at 3:05 PM, with Registered Nurse (RN) #1, at 3:10 PM, with LPN #7, at 4:00 PM, with UM #1, at 3:15 PM, with RN #7, at 3:25 PM, with LPN #3, at 3:45 PM, with UM #2, and at 4:05 PM, with UM #3 revealed all residents identified as a Full Code were checked every 4 hours for 72 hours and then each shift to ensure the yellow wristbands remained in place. Interview further revealed all Full Code residents were monitored every shift to ensure yellow bracelets were in place and this was documented on the residents' MARs.</p> <p>A review of audits revealed the SDC and or the UMs conducted weekly audits on 04/30/12, 05/01/12, and 05/02/12, of ten staff members to ensure comprehension of the Code Status policy, assessment skills, and actions to take when assessed to have a change in condition. No concerns were found with the audits.</p>	F 520		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702
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F 520	<p>Continued From page 54</p> <p>A review of the audits of the 24-hour reports revealed the UMs were conducting audits of the 24-hour nursing report five days a week. No concerns were found with the audits.</p> <p>A review revealed the UMs audited the MARs of residents identified to be Full Code status three times weekly on 05/01/12, 05/02/12, and 05/03/12, to ensure licensed staff was monitoring and documenting the yellow wristbands were in place.</p> <p>Interviews on 05/03/12, at 4:00 PM, with UM #1, at 3:45 PM, with UM #2, at 4:05 PM, with UM #3, and at 5:15 PM, with the SDC revealed they will conduct ten nursing staff audits weekly to ensure comprehension of the code status policy, assessment skills, and actions to take when a resident is identified with a change in condition. Interview further revealed the 24-hour nursing report would be audited daily five days a week, along with audits of the MARs for residents with Full Code status, three times a week, to ensure any resident who experienced a change in condition was assessed to ensure immediate action was taken to address the change in condition.</p>	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE, PO BOX 1304 CORBIN, KY 40702		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1989</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: 3-story, Type 11 (222)</p> <p>SMOKE COMPARTMENTS: 7</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 05/01/12, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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