

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

2nd SCD

PRINTED: 12/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  485232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  C 11/25/2014
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE CORBIN, KY 40702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An abbreviated standard survey (KY22508) was initiated on 11/24/14 and concluded on 11/25/14 The complaint was substantiated with deficient practice identified at "D" level.	F 000	Preparation or 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.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	F 225  1. Resident #4 was interviewed on 11/24/2014 by the Administrator upon notice from OIG of the alleged abuse. Resident #4 stated he had no ill effects from the incident with RN #3. Upon completion of the investigation, the Director of Nursing communicated the findings to the resident. Resident # 4 shall no longer receive care from RN# 3.  2. All residents have the ability to be affected by lack of reporting of suspected abuse to a supervisor or the Administrator. To protect all of the residents, RN#3 was suspended on 11/24/2014 by the DON pending the outcome of the investigation. APS, OIG, and local	

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

TITLE

(X6) DATE

Administrator

12/19/2014

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.

12/29/2014

*Bill Collins*

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F 225	Continued From page 1 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  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 all allegations involving mistreatment or abuse were reported immediately to the Administrator of the facility and to other officials in accordance with State law for one (1) of five (5) sampled residents (Resident #4). Interviews with Resident #4 and facility staff conducted on 11/24/14 and 11/25/14 revealed the resident voiced concerns of mistreatment by facility staff, related to an incident that occurred on 11/21/14. However, an interview with staff and the facility Administrator revealed the allegation was not reported or investigated, and residents were not protected as required by the facility's policy.  The findings include:  A review of the facility policy titled "Abuse Reporting and Prevention," last updated July 2001, revealed staff was required to report any observation, suspicion, or information obtained related to possible abuse to their supervisor immediately. The policy further stated if an employee received a verbal or written report of suspected or observed abuse, the employee should immediately examine the resident for any sign of injury, and inform the Administrator or designee.	F 225	Continued from page 1  authorities were notified of the incident on 11/24/2014. Current residents were interviewed regarding staff treatment of residents. Interviews were completed by Director of Nursing and Unit Managers on 12/19/14. No other issues were identified. Social Services Director and Unit Managers interviewed family members with a BIMs less than 8 regarding reports of suspected abuse/neglect. Interviews completed on 12/29/14 with no other issues identified.  3. The Abuse Reporting and Prevention Policy was reviewed by the Administrator on 11/25/14. The Staff Development Coordinator (SDC) re-educated all employees on the Abuse Reporting and Prevention Policy with the emphasis on reporting to a Supervisor or the Administrator any observation, suspicion, verbal or written report of Abuse or Neglect immediately.		

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F 225	Continued From page 2  A review of Resident #4's medical record revealed the facility admitted the resident on 07/11/14 with diagnoses that included Cervical Spine Stenosis, Functional Decline, and Hypertension. A review of a quarterly Minimum Data Set Assessment (MDS) dated 10/07/14 revealed the resident required limited assistance with ambulation and toileting. The MDS further revealed staff had assessed the resident to be interviewable with a Brief Interview for Mental Status (BIMS) score of 15.  An interview with Resident #4 on 11/24/14 at 4:05 PM revealed an incident had occurred on 11/21/14, involving a staff member (later identified as Registered Nurse #3). Continued interview revealed the resident told Registered Nurse (RN) #3, "you could have drowned me, and I want to speak to your boss." However, the resident stated no staff member, identified as the RN's supervisor, came to discuss the incident with the resident as requested. Continued interview revealed Resident #4 had also reported the incident to Physical Therapy Assistant (PTA) #1 on the morning of 11/24/14.  An interview with RN #3 on 11/25/14 at 10:30 AM confirmed Resident #4 had requested to speak with RN #3's supervisor on 11/21/14. RN #3 stated Resident #4 had told her that she (RN #3) "tried to kill" Resident #4 and told RN #3 to "call the supervisor." RN #3 stated she failed to contact the supervisor as the resident requested because the resident "calmed down." The RN stated she should have reported the incident to her supervisor as the resident had requested.  An interview with PTA #1 on 11/25/14 at 10:06 AM	F 225	Continued from page 2  She completed this education on 12/19/2014. New employees will continue to be educated on Abuse, Neglect and reporting upon hire by the CDC.  The Unit Managers will review the 24 hour report and complete skin assessments on 5 non-interviewable residents weekly for 12 weeks to determine if there are any signs or symptoms of abuse, then as directed by the Quality Assurance Performance Improvement Committee. The Don will review these with the Administrator.  The Social Services Director or the Chaplain will interview 5 residents and/or family members of residents with BIMs less than 8 regarding reports of suspected abuse/neglect weekly for 12 weeks to determine if there have been any instances of perceived abuse or neglect, then as directed by the		

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F 225	Continued From page 3 confirmed Resident #4 had voiced concerns with treatment he/she had received from facility staff and stated "someone had just dumped water" into his/her nose. The PTA stated she offered to have the facility Social Worker speak with the resident; however, the resident declined. The PTA stated even though she had been trained to report allegations of abuse and mistreatment, she failed to report the incident. The PTA stated she should have reported the incident to Administrative staff as required.  An Interview with the Administrator on 11/25/14 at 4:15 PM revealed staff had been educated to report allegations of abuse and or mistreatment, which involved facility residents. Continued interview revealed RN #3 should have contacted the supervisor as requested by the resident. He also stated PTA #1 should have reported the allegation voiced by Resident #4 to Administrative staff as required.	F 225	Continued from page 3  Quality Assurance Performance Improvement Committee. These interviews will be reviewed with the Administrator.  4. The Administrator will review the findings of the Audits with the Quality Assurance Performance Improvement Committee monthly, where the effectiveness of the actions taken will be evaluated.	12/30/14
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION  When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's grievance procedure it was determined the facility failed to follow up with one (1) of five (5) sampled residents (Resident #1)	F 244	F 244  1. Resident #1 attended a care plan conference with her son on 10/2/14 and on 11/11/2014. At that time he/she stated there was not a concern related to call light response. On 11/24/2014 Resident #1 was interviewed about call light concerns by the DON. A grievance form was initiated and completed for this concern. The resident was informed by the	

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F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION  When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's grievance procedure it was determined the facility failed to follow up with one (1) of five (5) sampled residents (Resident #1)	F 244	F 244  1. Resident #1 attended a care plan conference with her son on 10/2/14 and on 11/11/2014. At that time he/she stated there was not a concern related to call light response. On 11/24/2014 Resident #1 was interviewed about call light concerns by the DON. A grievance form was initiated and completed for this concern. The resident was informed by the		

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F 244	<p>Continued From page 4</p> <p>who voiced a grievance related to facility response time to call lights. Interview with Resident #1 on 11/24/14 revealed the resident had voiced concerns to the facility Director of Nursing (DON) and the facility Ombudsman in October 2014 about his/her concerns with call lights. The resident stated no one had followed up with him/her related to the concerns and call lights continued to be left unanswered and/or call lights were turned off, even though the resident's needs were not met.</p> <p>The findings include:</p> <p>A review of the facility's grievance procedures, not dated, revealed anytime a resident felt they were not treated fairly, or if they felt an employee had mistreated them in any way, residents could take steps to correct or eliminate the problem. Residents were to notify the appropriate Nurse Manager/Director of Nursing or Social Services Representative, who would assist the residents in investigating and solving the problem. A review of the facility's grievance investigation form revealed facility staff should document that they followed up with the resident after an investigation of the concern was conducted.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 04/24/14, with diagnoses that included Congestive Heart Failure and Status Post above the Knee Amputation. A review of the quarterly Minimum Data Set Assessment (MDS) dated 10/26/14 revealed the resident required limited assistance with dressing and bathing. The MDS further revealed staff had assessed the resident to be interviewable with a Brief Interview for Mental Status (BIMS) score of 15.</p>	F 244	<p>Continued from page 4</p> <p>Director of Nursing on 11/28/2014 of an action plan and follow up by Social Services to resolve this concern. Resident # 1 was satisfied with the resolution.</p> <ol style="list-style-type: none"> <li>All residents have the ability to be affected by call light response time. All alert and oriented residents were interviewed by the DON and Unit Manager to see if there were any unresolved grievances on 11/24/2014. No grievances were identified.</li> <li>The Grievance Policy was reviewed by the Administrator on 11/25/2014. All staff members were re-educated on the Grievance Policy including the need to inform the resident / family member of the resolution of the grievance by the DON and SDC. This education was completed on 12/19/2014.</li> </ol> <p>The Social Services Director (SSD) or the Chaplain will interview 5</p>		

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F 244	Continued From page 5  An interview with Resident #1 on 11/24/14 at 9:20 AM revealed, "Call lights are an ongoing problem here." The resident further stated the concern with call lights had been discussed with the facility Ombudsman on two different occasions. Resident #1 was unsure of the exact dates but stated the first discussion with the Ombudsman was in early October 2014. Resident #1 further stated the call light concern had also been discussed with the DON approximately three weeks earlier. The resident stated the DON had not followed up with the resident to ensure the call light concern had been resolved and stated, "Nothing's changed with the call lights."  An interview with the DON on 11/25/14 at 2:50 PM confirmed the facility Ombudsman had notified her on two different occasions in October of Resident #1's complaints related to call lights not being answered in a timely manner (10/10/14 and 10/28/14). The DON further stated Resident #1 had voiced in October 2014 that he/she "felt like the call lights took a little time to be answered." The DON stated she had interviewed other residents (unsure of which residents or exact dates) but identified no other concerns. The DON further stated she had conducted call light audits, which were initiated on 11/20/14 (41 days after the resident's initial concern was voiced), and no concerns had been identified through the audits. The DON stated that she had not followed up with the resident, but she had not been notified that Resident #1 was "still complaining about the call lights."  An interview with the Administrator on 11/25/14 at 4:15 PM revealed the Ombudsman had notified him of call light concerns voiced by Resident #1,	F 244	Continued from page 5  residents weekly for 12 weeks to determine if they have any grievances or concerns to report for, then as directed by the Quality Assurance Performance Improvement Committee. These interviews will be reviewed with the Administrator. The Administrator or the Business Office Manager will review the Grievance logs weekly for 12 weeks to ensure the person filing the grievance has been made aware of the resolution, then as directed by the Quality Assurance Performance Improvement Committee.  4. The Administrator will review the findings of the Audits with the Quality Assurance Performance Improvement Committee monthly, where the effectiveness of the actions taken will be evaluated.	12/29/14	

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F 244	Continued From page 6 in October 2014. The Administrator stated the Ombudsman had "looked into and unsubstantiated the resident's concerns that day, and I thought everything was fine." The Administrator further stated he felt like it was the Ombudsman's responsibility to "check the complaints out." There was no evidence that indicated facility staff had conducted a follow-up interview with Resident #1 to ensure the resident's grievance was resolved.	F 244			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  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 resident call lights were answered and residents' needs were met for two (2) of five (5) sampled residents (Residents #1 and #4) and one (1) unsampled resident (Resident A). Interviews conducted with facility residents revealed staff did not respond to call lights in a timely manner and the residents waited up to thirty (30) minutes for assistance or staff turned off the call light and never met the resident's need.	F 309	F 309  1. Residents 1, 4, and A were interviewed by the DON on 11/24/2014 related to the timeliness of having their call lights answered, help received, and the follow up if the staff answering the light was unable to complete the request. An action plan was completed for any identified concern. These residents were notified of the action plan / resolution on 11/28/2014 by the DON and follow up completed by the SSD to assure resolution of the identified concern.  2. All residents have the ability to be affected by call light response		

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F 309	<p>Continued From page 7</p> <p>The findings include:</p> <p>A review of the facility policy titled "Call Light System," not dated, revealed staff was required to answer residents' call lights as quickly as possible. The policy further stated staff was to help the resident, and if staff was unable to provide the resident with the item or service they had requested, then staff was to return to the resident quickly with a reply.</p> <p>A review of a list of interviewable residents provided by the facility revealed facility staff assessed Resident #1, Resident #4, and Resident A to be interviewable, with Brief Interview for Mental Status (BIMS) scores of 15.</p> <p>An interview with Resident #1 on 11/24/14 at 9:20 AM revealed that at times call lights rang for 30 minutes before they were answered by facility staff. The resident continued to state, "They are also bad to come in and turn my call light off. I will tell them what I need, but then they leave and never return to help me."</p> <p>During an interview with Resident #4 on 11/24/14 at 4:05 PM, Resident #4 stated, "Waiting on my call light to be answered is my biggest problem." The resident further stated, "At least once a day, I will push my call light to get help. They come in, turn it off, and they leave and never come back."</p> <p>An interview conducted with Resident A on 11/25/14 at 1:00 PM revealed facility call lights were "sometimes answered slowly." Resident A stated that he/she had waited 20 minutes or longer for the call light to be answered by staff. Continued interview revealed staff had entered the resident's room, turned off the resident's call</p>	F 309	<p>Continued from page 7</p> <p>time. Current residents were interviewed regarding the timeliness of having their call lights answered and help received. Interviews were conducted by the Director of NURSING and Unit Managers on 12/19/2014. No additional issues identified.</p> <p>3. The Administrator and DON reviewed and revised the Call light System Policy to include the expectation of the staff to leave a resident's call light on until the need has been met on 12/09/2014.</p> <p>The SDC re-educated the Nursing staff on the Call light system Policy. The education was completed on 12/19/2014.</p> <p>Call light audits to include timeliness of answering and needs met will be completed weekly by a Nurse Manager for 8 weeks, Bi-weekly for 4 weeks, monthly for 3 months, then as recommended by the Quality Assurance Performance</p>		

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 118 SOUTH COMMONWEALTH AVENUE CORBIN, KY 40702		
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F 309	Continued From page 8 light, left the room, and failed to return to provide the assistance requested.  An interview with SRNA #1 on 11/24/14 at 3:40 PM revealed, "Sometimes call lights do have to wait longer than they should, especially during meal service." The SRNA stated, "If we had more staff, call lights could be answered in a good timeframe, like they should be."  An interview with Registered Nurse (RN) #2, also the Unit Manager, on 11/25/14 at 1:50 PM revealed residents had voiced complaints related to call lights. The RN stated she had spoken with residents related to their complaints; however, residents were not able to remember what shift, or what staff member was working when the call lights were not answered timely. The RN stated the call light complaints "seems to be a continuous thing."  An interview with the Director of Nursing (DON) on 11/25/14 at 2:50 PM revealed she was not aware that there were any current concerns with call lights not being answered in a timely manner.	F 309	Continued from page 8  Improvement Committee. The DON will review these audits weekly with the Administrator.  4. The Administrator will review the findings of the Audits with the Quality Assurance Performance Improvement Committee monthly, where the effectiveness of the actions taken will be evaluated.	12/29/14	