STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185147	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTIAN HEALTH CENTER	**200 STERLING DRIVE HOPKINSVILLE, KY 42240**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review. it was determined the facility failed to ensure care plan interventions were implemented for one (1) of twenty (20) sampled residents (Residents #56). Resident #56 was care planned to receive [MED]gen (O2) at two (2) liters per minute (lpm); however, observations revealed Resident #56's [MED]gen concentrator was set at 1.5 LPM or 2.5. The findings include: Review of the facility's policy titled, Care Plan, Comprehensive, last revised July 2013, revealed an individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. However, the policy did not address the implementation of care plan interventions. Record review revealed the facility admitted Resident #56 on [DATE], with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 0[DATE], revealed the facility assessed Resident #56's cognition as not intact with a Brief Interview for Mental Status (BI[CONDITION]) score of ninety-nine (99), which indicated the resident was not interviewable. Review of Resident #56's Comprehensive Care Plan for [MEDICAL CONDITION], dated 08/09/19, revealed an intervention to provide O2 at two (2) lpm per nasal cannula (n/c), as needed (PRN). However, observations on 03/09/19 at 11:25 AM and 12:34 PM, revealed Resident #56's O2 cannula was in place and O2 was turned on with a reading of 1.5 lpm. Further observations on 0[DATE]20 at 8:38 AM and on 03/11/2020 at 8:22 AM, revealed Resident #56's O2 cannula was in place and O2 concentrator was turned on with a reading of 2.5 lpm. Interview with Registered Nurse (RN) #1 on 03/11/2020 at 8:45 AM, revealed Resident #56's O2 was care planned to be on at two (2) lpm. She stated the nurse should check the O2 concentrator at least once per shift to ensure correct setting. RN #1 further revealed staff should follow what is on the resident's care plan while providing daily care. Phone interview with RN #3 on 03/11/20 at 1:39 PM, revealed she could not recall Resident #56's exact order for O2 setting but she recalled checking the O2 concentrator on the morning of 0[DATE]20 and again that afternoon before she gave the resident pain medication. She acknowledged care plans should be followed. Interview with the Director of Nursing (DON) on 03/11/19 at 2:46 PM, revealed licensed nurses were responsible for ensuring the care plan were followed related to administering O2.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure two (2) of three (3) residents who were incontinent of bladder in the select sampled of twenty (20) residents received appropriate treatment and services to prevent urinary tract infections to the extent possible (Residents #23 and #66). Observations of incontinent care for Resident #23 and Resident #66 revealed staff failed to follow its policy regarding incontinence care, bladder/perineal care and infection control by contaminating the cleaning process and using improper handwashing techniques. The findings include: Review of the facility policy titled, Incontinence Care, Bladder/Perineal Care, last revised August 2016, revealed the purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Further review of the policy revealed instructions to apply soap or skin cleansing agent to clean washcloth and wash periarea using clean technique, remove the disposable gloves, discarding them into designated container, and to wash hands after pericare has been provided and prior to reposition the covers or touching any other surfaces in patient area. 1. Record review revealed the facility admitted Resident #23 on 11/02/16, with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 12/17/19, revealed the facility assessed Resident #23's cognition as intact with a Brief Interview for Mental Status (BI[CONDITION]) score of fourteen (14) which indicated the resident was interviewable. Review of Resident #23's Comprehensive Care Plan for at risk for infection and at risk for injury related to right sided [MEDICAL CONDITION] and has a urinary tract infection dated 11/3/16, revealed an intervention to provide incontinence care after each episode per facility protocol and according to standards of care. Observation of perineal (peri) care on 03/11/2020 at 9:49 AM, for Resident #23 revealed State Registered Nurse Aide (SRNA) #1 soiled her gloves, and placed the dirty washcloth back in the water basin that she used for pericare, then picked up a clean washcloth soaking in the contaminated water, and continued providing peri care. SRNA #1 then proceeded to change the water in the basin, leaving her soiled gloves on. SRNA #1 touched the bedding and turned the resident without changing her soiled gloves. After finishing repositioning Resident #23, SRNA #1 removed her gloves without washing her hands, then picked up the trash and left the room without washing her hands. Interview with SRNA #1 on 03/11/20 at 10:18 AM revealed placing the dirty washcloth in water with clean washcloths was an infection control issue and could contribute to the resident developing an UTI. She stated she should have removed her gloves immediately after they became soiled, and washed her hands. Interview with Registered Nurse (RN) #2 on 03/11/20 at 10:37 AM, revealed placing soiled washcloths back into the water basin and wetting clean washcloths or reusing any washcloths in this water basin would be a cross contamination and infection control issue and may contribute to the development of an UTI. Interview with Director of Nursing (DON) on 03/11/20 at 02:41 PM, revealed CNA's were responsible for pericare and she expected them to use infection control protocols to prevent cross contamination and infection during pericare. The DON stated she expected the CNA's to not put a soiled washcloth back in the water basin after using, to change gloves, empty basin if contaminated, and take soiled gloves off at bedside to ensure proper sanitation and infection control. 2. Record review revealed the facility admitted Resident #66 on 05/22/14 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated 02/04/2020, revealed the facility assessed Resident #66's cognition as intact with a BI[CONDITION]' score of fifteen (15) which indicated the resident was interviewable. Interview with Resident #66 on 0[DATE] at 9:13 AM revealed she has an UTI because staff do not clean him/her often enough, and he/she had been on antibiotics for the last seven (7) days and continues to have symptoms of itching and burning. Review of Resident #66's Comprehensive Care Plan for at risk and has history of actual impaired skin integrity with occasional moisture associated skin damage revealed interventions to check for incontinence every two (2) hours and at night; and, to provide pericare, clean and dry skin if wet or soiled. Observation of Resident #66's pericare on 03/11/2020 at 5:35 PM revealed SRNA #1 failed to use infection control measures when he/she touched the wipes container with soiled gloved hand and used that same soiled glove hand to continue giving pericare to resident. Further observation revealed SRNA #1 did not remove glove after performing pericare and proceeded to touch the resident's linen, bedside dresser, and bedpan, before finally removing the soiled glove. Interview with SRNA #1 on 03/11/20 at 10:16 AM revealed she should have pulled soiled gloves off after touching resident's

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.

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) periarea and before touching the container of wipes and returning to provide pericare. She stated it was the facility's policy and it violated infection control procedure when she touched Resident #66's bed linens, dresser, and bed pan, before taking the soiled glove off. She stated these actions could contribute to UTI's in residents. Interview with RN #2 on 03/11/20 at 10:43 AM, revealed it was a cross contamination and infection control issue for a staff member to use soiled gloved hand to touch wipes container and then retouch resident's peri area with same gloved hand. She stated touching other items such as residents dresser, bed linens and bed pan before removing soiled glove was also an infection control and cross contamination issue and was not an acceptable standard of practice. Interview with DON on 03/11/20 at 02:41 PM, revealed once a staff's gloved hand giving pericare is lifted off the perineal area, it is considered soiled and gloves need to be removed, hands washed, and hands re-gloved before continuing pericare area care and touching any other objects, for example, wipes container, linens, dresser or bed pan. She stated touching any object with soiled glove is an infection control issue and is not standard protocol and that staff has been educated numerous times on facility policy and standards of care. She revealed she expected staff to follow facility policy and standard precautions when providing any care to residents.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, it was determined the facility failed to provide [MED]gen (O2) therapy according to the physician's orders [REDACTED].#56). Observations on 03/09/2020, 0[DATE]20, and 03/11/2020, revealed staff failed to administer O2 at 2 liters per minute (lpm) via nasal cannula (n/c) for Resident #56, as ordered. The findings include: Review of the facility's policy, Oxygen Therapy - Concentrator, last revised 01/23/2012, revealed [MED]gen therapy is administered only as ordered by a physician or as an emergency intervention until an order can be obtained. The physician's orders [REDACTED].g., cannula, mask, etc. and the rate of flow of [MED]gen. The policy further revealed before administering [MED]gen, and while the resident is receiving [MED]gen therapy, assessments should be completed to include vital signs and to check the [MED]gen concentration. Record review revealed the facility admitted Resident #56 on [DATE], with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 0[DATE], revealed the facility assessed Resident #56's cognition as not intact with a Brief Interview for Mental Status (BI[CONDITION]) score of ninety-nine (99), which indicated the resident was not interviewable. Review of Resident #56's Comprehensive Care Plan for [MEDICAL CONDITION], dated 08/09/19, revealed an intervention to provide O2 at two (2) lpm per n/c, as needed. Review of Resident #56's physician's orders [REDACTED].> 90 %, as needed (PRN). Observations on 03/09/19 at 11:25 AM and 12:34 PM, revealed Resident #56's was wearing n/c to nares with O2 turned on and set at 1.5 lpm. Observations on 0[DATE]20 at 8:38 AM and on 03/11/2020 at 8:22 AM, revealed Resident #56's was wearing n/c to nares and O2 was turned on and set at 2.5 lpm. Interview with Registered Nurse (RN) #1 on 03/11/2020 at 8:45 AM, revealed Resident #56's O2 was ordered to be on 2 lpm. She stated nurses should check O2 settings at least once per shift to ensure correct settings. RN #1 further revealed staff should follow what is on the resident's care plan and physician's orders [REDACTED].#3 on 03/11/20 at 01:39 PM, revealed she could not recall the exact order for the O2 settings for Resident #56 but she recalled checking the machine and O2 level on the morning of 0[DATE]20 and again that afternoon before she gave the resident pain medication. She stated care plans and physician's orders [REDACTED]. She made mention that looking at the setting on the machine can be subjective to person's looking and their position when eyeing it and maybe she should pay more attention to ensure the settings are on the line at the appropriately ordered mark. Interview with the Director of Nursing (DON) on 03/11/19 at 2:46 PM, revealed the licensed nurses were responsible for verifying physician orders [REDACTED]. She stated she expected the nurses to follow physician orders [REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure drugs used in the facility were labeled in accordance with currently accepted professional principles. On 03/09/2020, observation of the medication room refrigerator revealed one (1) vial of [MEDICATION NAME] ([MEDICATION NAME] protein derivative) solution opened and expired. The findings include: Review of the facility's policy titled, Storage and Expiration of Medications, Biological's Syringes, and Needles, last revised 10/31/2016, revealed the facility shall not use outdated drugs or biological's and all such drugs shall be returned to the dispensing pharmacy or destroyed. Observation of the refrigerator in the [LOC], on 03/09/2020 at 3:36 PM, revealed a vial of [MEDICATION NAME], dated opened on 02/04/2020. However, the medication expired thirty (30) days after opening (03/05/2020); and it was still available for use. Interview with Licensed Practical Nurse (LPN) #1, on 03/09/2020 at PM, revealed the vial of [MEDICATION NAME] should have been discarded because it expired after thirty (30) days. She stated all nursing staff were taught during their orientation to date multi-dose medications and to dispose of expired medications. Interview with the Director of Nursing (DON), on 03/11/2020 at 2:31 PM, revealed she expected the nurses to discard expired medications such as [MEDICATION NAME] because the solution expires thirty days after opening. She stated nursing staff are educated on expiration dates of medications during their orientation upon hire.