

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Christian Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 Westen Avenue Bowling Green, KY 42104	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47567</p> <p>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure all drugs and biologicals were kept under lock when not attended. In addition, medications/solutions were not dated when opened (to indicate an expiration date) and/or disposed of when expired. This failure affected one of two medication carts and one of three medication rooms that were audited.</p> <p>The findings include:</p> <p>Review of an undated facility policy, titled, Medication Storage in the Facility, revealed medications and biologicals are to be stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Further review revealed outdated, contaminated, or deteriorated medications are to be immediately removed from stock and disposed of according to procedures for medication disposal.</p> <p>1. Observation upon entrance to the facility on [DATE] at 10:38 AM, revealed Registered Nurse (RN) 1 administering medications to residents sitting in the common living room area on the 100 Hall. RN1 walked away from the medication cart and left the cart (which contained multiple medications) unlocked and unattended for approximately five minutes while she entered the medication supply storage room to gather additional supplies.</p> <p>In an interview with RN 1 on 08/20/2024 at 2:30 PM, she stated that medication carts should be locked at all times if the staff was not getting into them to get something out. In addition, per RN1, the medication cart should be locked after staff get medications out, before walking away to give them to a resident. She further stated that she did not realize that she had walked away from the cart and left it unlocked. She stated that she knows better and had no explanation as to why she walked away and did not lock her cart. She stated it is dangerous to leave a medication cart unlocked because wandering residents and others could get into them and may take things, especially if the cart is left in an accessible area.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an observation of medication administration on 08/21/2024 at 8:27 AM, Certified Medication Technician (CMT) 2 walked away from the medication cart to administer medications to Resident (R) 13 and did not lock the cart. The unlocked medication cart was left in the hallway, while CMT2 was in the resident's room. In addition, CMT2 did not secure a controlled medication (one capsule of Gabapentin) that was to be wasted. The controlled medication was left sitting on top of the unlocked, unattended medication cart.</p> <p>In an interview with CMT 2 on 08/21/2024 at 9:34 AM, she stated that she forgot to lock her cart and secure the controlled medication before going to administer medications to the resident. She further stated she forgot the controlled medication was still sitting on top of the medication cart, as she was waiting for a nurse to become available and witness the waste of the medication with her. She stated a resident, or anyone else, could get into her cart and take some medications if it was left unlocked and unattended.</p> <p>3. Observation of Medication Storage room [ROOM NUMBER] on 08/21/2024 at 4:00 PM, revealed one vial of Tubersol Solution, with an expiration date of 05/01/2027, that was stored in the medication refrigerator. The vial was opened but not dated. In addition, observation revealed three vials of glucose control level 2 solutions with expiration dates of 01/17/2023, 11/14/2023, and 08/15/2024.</p> <p>In an interview with Licensed Practical Nurse (LPN) 1 on 08/21/2024 at 3:20 PM, she stated that all nurses were responsible for checking the supply storage rooms on a monthly basis. LPN1 stated that they just overlooked the expired solutions when performing their last check. LPN1 confirmed that nursing is ultimately responsible for checking the rooms and making sure everything is up to date and stored correctly.</p> <p>In an interview with the 300 Hall Unit Manager on 08/21/2024 at 4:00 PM, she stated the room was used to store the overflow medications and supplies and did not know if the nursing staff was using the supplies out of the Medication Room on the 300 Hall. Further interview with the Unit Manager revealed that they were ultimately responsible for the storage rooms.</p> <p>In an interview with the Director of Nursing (DON) on 08/23/2024 at 8:46 AM, she stated she expects proper storage of medications, with staff keeping them safe and secure. The DON stated that anyone could come through and retrieve medications if they were to walk by an unlocked cart. She also stated her expectation was that staff keep stock up to date, adding that nurses are trained to look at expiration dates. The DON stated staff are aware of the need to check dates on items because things can expire quickly. She added that they try not to keep expired things in their medication rooms, but staff should look at dates and make sure that they do not use those items.</p> <p>In an interview with the Administrator on 08/23/2024 at 8:32 AM, he stated anything that is getting close to being expired should be used or discarded. He further stated his expectations is for staff to be accurate at all times, and not have expired medications on the floor or in a supply room.</p>		