| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185419 | A. Building<br>B. Wing | 01/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Christian Health Center | 1800 Westen Avenue<br>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) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure the comprehensive person-centered care plan was implemented for each resident to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 4 sampled residents, Resident (R)37.On 04/09/2025, Certified Nursing Assistant (CNA) 10 failed to implement the Comprehensive Care Plan intervention added 02/25/2025, requiring a total lift with green sling and assistance of two staff for transfers. CNA10 transferred the resident independently without the mechanical lift resulting in a laceration to R37's right lower leg. R37 was transferred to the local hospital for sutures. The findings include:Review of the facility's policy titled, Care Planning, revised 03/27/2024, revealed it was the policy of the facility to develop and implement a baseline and comprehensive person-centered care plan for each resident that reflected the resident's medical, nursing, mental, and psychosocial needs.Review of R37's Face Sheet revealed the facility admitted the resident on 09/18/2024 with diagnoses including unspecified dementia, scoliosis, and overactive bladder.Review of R37's Annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/10/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Further review revealed the resident was dependent on staff for chair/bed to chair transfer.Review of R37's Comprehensive Care Plan, dated 09/20/2024, revealed R37 had a self-care deficit related to needing assistance with activities of daily living (ADL) and was at risk for decline related to impaired mobility. The interventions included: provide assistance with ADLS, assistance of two (2) staff, encourage resident to be as independent with ADLs as possible, and assess resident for needed equipment or assistive devices to maximize independence. Additional review revealed on 02/25/2025, a new intervention was added indicating R37 required a total lift with green sling and assistance of two staff for transfers. Review of the Comprehensive Device Assessment, dated 02/25/2025, revealed R37's assistive devices included a wheelchair, a total lift with a green sling, and also side rails for positioning. Additionally, R37 was to use the green sling during transfer to the tub.Review of R37's current Assignment Sheet, revealed the resident required a lift with 2 person assist with the green sling.Review of R37's Progress Note, dated 04/09/2025 at 3:39 PM, written by Registered Nurse (RN)5, revealed, at 2:30 PM the resident was being transferred from wheelchair to bed by CNA10 when she sustained a vertical cut to her right lower extremity that extended full thickness to the bone. Continued review revealed bleeding was controlled, and the physician, Unit Manager, Director of Nursing (DON) and the resident's son was made aware. R37 was transported to the hospital by ambulance.Review of R37's Patient Health Summary, dated 04/09/2025, from the local hospital, revealed the resident's encounter diagnosis was laceration of leg. The discharge care plan revealed the resident sustained a right leg laceration and her condition was stable. The instructions included: warm soapy washes daily and apply a light coating of antibiotic ointment. Elevate<br><br>(continued on next page) |

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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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | it once or twice a day if it starts to swell. Can place a light ace wrap or compression hose over it because you do not really want any swelling. Recheck in 2-3 days. Sutures should be removed in 10 days by family doctor. Observation and concurrent interview with R 37, on 01/14/2026 at 4:00 PM, revealed there was a lift sling in R37's wheelchair. The State Survey Agency (SSA) Representative asked R37 if staff used a lift to transfer her out of the bed, and she stated yes. She then stated she received a big cut on her leg when an aide tried to move her without the lift. R37 stated she could not remember everything about it but she did remember that much. Telephone interview attempts with CNA10 were unsuccessful on 01/14/2026 at 2:18 PM; and on 01/15/2026 at 11:56 AM and 3:15 PM. In an interview with Registered Nurse (RN)5, on 01/15/2025 at 3:10 PM, she stated she was the nurse on the 300 hall on 04/09/2025 when CNA10 informed her R37 was bleeding. Further, CNA10 informed her she had transferred R37 to the bed from the wheelchair. RN5 stated she went to the resident's room and observed a large cut to R37's lower right leg from the iron bed frame. During additional interview on 01/15/2025 at 3:10 PM, RN5 stated she called the Unit Manager and the DON. She further stated the DON had her call the physician, and she also called emergency medical services (EMS) to transport R37 to the hospital emergency room. RN5 stated R37 required the use of a total body lift (mechanical lift) and assistance of two staff for transfers, and CNA10 was aware. RN5 further stated the CNAs received an assignment sheet at the beginning of the shift, and the information showing type of transfer required was on the assignment sheet. In an interview with CNA2 on 01/15/206 at 3:46 PM, she stated she had been at the facility for about 2 years. She stated she worked all units in the facility and had provided care for R37 before. CNA2 stated R37 required a lift for transfers and assistance of two (2) people. She stated she received an assignment sheet at the beginning of her shift. CNA2 stated if a resident required a lift, it would be on the assignment sheet. She further stated the color of the sling a resident used would be on there as well. Additionally, she stated when using a mechanical lift, two people were required when transferring a resident. CNA2 further stated she could also review care plans on the computerIn an interview with CNA4, on 01/15/2026 at 4:22 PM, she stated she worked all units in the facility, and all units used the same assignment sheets. She stated CNAs were to keep their assignment sheets in their pockets and review them if they were not familiar with a resident. She further stated if a resident used a mechanical lift, it would be on the assignment sheet and would be marked two (2) assist and the color of the sling to use would be noted. She stated she could also access the care guide on the computer (electronic health record).In an interview with the MDS Nurse, on 01/15/2026 at 4:11 PM, he stated he had been completing MDS Assessments for about 18 months. He stated the unit managers assisted him with completing the comprehensive care plans. He further stated staff nurses could add to the care plans, but he and the unit managers completed most of the updates. The MDS nurse stated the purpose of the care plan was to ensure the staff were following standards of care based on a resident's specific needs. He stated we would expect staff to follow interventions that were in place on the plan of care. In an interview with the Director of Nursing (DON), on 01/15/2026 at 5:14 PM, she stated it was her expectation staff follow the interventions on the care plan. She stated the facility had a skills check off with education provided in March 2025 which included use of the total lift.The DON further stated CNA10 was aware R37 required a lift (mechanical lift) and two (2) assist for transfers but transferred her anyway, resulting in an injury.In an interview with the Interim Executive Director (ED), on 01/15/2026 at 6:39 PM, she stated CNA10 transferred R37 by herself because she thought she could do it without using the lift. The ED stated she expected staff to follow resident care plans. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 4 sampled residents, Resident (R) 37.On 04/09/2025, Certified Nursing Assistant (CNA) 10 transferred R37 by herself and without the use of a total lift (mechanical lift). However, the resident was assessed and care planned to be transferred by a total lift with 2 staff members. R37 sustained a laceration to her right lower leg requiring transfer to the hospital emergency room for sutures. The findings include:Review of the facility's policy titled, Accidents and Supervision, dated 04/2025, revealed the residents' environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This included implementing interventions to reduce hazards and risks, monitoring for effectiveness, and modifying interventions when necessary. Continued review revealed implementing interventions meant using specific interventions to try to reduce a resident's risks from hazards in the environment.During an interview with the Interim Executive Director on 01/14/2025, she stated the facility did not have a policy on the use of mechanical lifts. (A mechanical lift is a device, often battery or electrically powered to safely move individuals with limited mobility). Review of Resident (R)37's Face Sheet, revealed the facility admitted the resident on 09/18/2024 with diagnoses including unspecified dementia, scoliosis, and overactive bladder.Review of R37's Annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/10/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Further review revealed the resident was dependent for chair/bed-to-chair transfer and utilized a wheelchair.Review of R37's Comprehensive Care Plan dated 09/20/2024, revealed the resident was care planned as having a self-care deficit related to needing assistance with activities of daily living (ADL) and at risk for decline related to impaired mobility. The interventions included: provide assistance with ADLS, assistance of two (2) staff, encourage resident to be as independent with ADLs as possible, and assess resident for needed equipment or assistive devices to maximize independence. Additional review revealed on 02/25/2025, a new intervention was added indicating R37 required a total lift with green sling and assistance of two staff for transfers.Review of the Comprehensive Device Assessment, dated 02/25/2025, revealed R37's assistive devices included a wheelchair, a total lift with a green sling, and side rails for positioning. Further, R37 was to use the green sling during transfer to the tub.Review of R37's current Assignment Sheet, revealed the resident required a lift with 2 persons assist and a green sling.Concurrent observation and interview with R37 on 01/14/2026 at 4:00 PM, revealed a lift sling in R37's wheelchair. R37 was questioned if staff used a mechanical lift to get her out of bed, and she stated yes. R37 further stated she got a big cut on her leg when an aide tried to move her without the lift. She stated she couldn't remember everything about it, but she did remember that much.Review of R37's Progress Note, dated 04/09/2025 at 3:39 PM, signed by Registered Nurse (RN)5, revealed at 2:30 PM, resident was being transferred from the wheelchair to bed by CNA10 when she sustained a vertical cut to her right lower extremity that extended full thickness to the bone. Bleeding was controlled, and the physician, Unit Manager, Director of Nursing (DON), and R37's son were made aware. Resident was transported to the hospital by ambulance.Review of R37's Patient Health Summary, dated 04/09/2025, from the local hospital, revealed the encounter diagnosis was laceration of the leg. The discharge care plan stated: right leg laceration and condition stable. Additional instructions included: warm soapy washes daily and apply a light coating of antibiotic ointment. Elevate it once or twice a day if it starts to swell. Can<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | place a light ace wrap or compression hose over it because you do not want any swelling. Recheck in 2-3 days, sutures should be removed in 10 days by family doctor. Tylenol as needed for pain. There is no fracture or any other abnormality on the x-ray except the bones are thin with osteoporosis.Review of the facility's Final Report/5 Day Follow-Up, dated 04/16/2025, revealed after a thorough investigation, it was determined despite documented and verified recent training on use of Hoyer lift (mechanical lift) on 03/27/2025, CNA10 did not use the mechanical lift as care planned. As a result, R37 sustained a laceration to her right leg.Review of CNA10's Employee File, revealed a hire date of 03/13/2025. Continued review revealed all required checks were completed on 03/13/2025.Review of the document titled, Counseling/Discipline Record, revealed the Director of Nursing (DON) issued a final written warning to CNA10 on 04/11/2025. Per the document, the investigation revealed, on 04/09/2025, CNA10 transferred R37 from her bed without using the required Hoyer lift. CNA10 admitted to transferring the resident without using safety equipment. R37 received an injury while in the process of being moved.During an interview with Registered Nurse (RN)5, on 01/15/2025 at 3:10 PM, she stated she was the nurse on the 300 hall on 04/09/2025. She stated CNA10 informed her R37 was bleeding after she transferred the resident to the bed from the wheelchair. RN5 stated she went to the resident's room and observed R37 had a large cut to the right lower leg from the iron bed frame.During further interview with RN5, on 01/15/2025 at 3:10 PM, she stated she called the Unit Manager and the DON. She further stated the DON had her call the physician, and she also called emergency medical services (EMS) to transport R37 to the emergency room. RN5 stated R37 required the use of a total body lift and assistance of two staff for transfers, and CNA 10 was aware. RN 5 stated the CNAs received an assignment sheet at the beginning of the shift, and instructions on how to transfer the resident were on the assignment sheet.Telephone interview attempts with CNA 10, who transferred R37 on 04/09/2025 were attempted, but were unsuccessful on 01/14/2026 at 2:18 PM; and on 01/15/2026 at 11:56 AM and 3:15 PM.In an interview with CNA3, on 01/15/2026 at 3:57 PM, she stated she worked as needed (PRN) and worked in all areas of the facility. She stated she was familiar with R37 and knew the resident required a total lift for transfers. She stated the amount of assistance a resident required (one or two people) was noted on the assignment sheets for all units. She further stated if a resident used a lift, the sling color would also be on the sheets.During an interview with the Director of Nursing (DON), on 01/15/2026 at 5:14 PM, she stated she had been at the facility for 21 years. She further stated she was made aware of R37's incident immediately by RN5. The DON stated she went upstairs to R37's room and saw CNA10 holding pressure to R37's leg. She stated she asked RN5 what happened, and RN5 stated CNA10 attempted to transfer R37 by herself without using the lift. The DON stated she told RN5 to call the physician and send her to the hospital Emergency Department (ED) because the cut was pretty bad.During continued interview with the DON, on 01/15/2026 at 5:14 PM, she stated she had a discussion with CNA10 and she was suspended. She stated CNA10 did not give a reason for transferring R37 by herself without a lift and informed her she had done it before. She stated CNA10 was aware R37 required a lift and two (2) assist for transfers but transferred her without the lift anyway. The DON further stated CNA10 did not have her assignment sheet on her at the time which would have shown the resident was to be transferred with a lift and two staff members.During an interview with the Interim Executive Director (ED), on 01/15/2026 at 6:39 PM, she stated she was in the facility when R37's incident occurred and was notified immediately. She stated she was the Assistant Executive Director at that time. She stated CNA10 transferred R37 by herself because she thought she could do it without using the lift. She further stated CNA10 was suspended following the incident. In continued interview, the Interim Executive Director (ED) stated she expected staff to follow resident care<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | plans. She stated the facility had zero tolerance and had terminated staff for not following the plan of care. |