

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

PRINTED: 01/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/19/2016
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 01/02/16 as alleged.</p>	{F 000}		
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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.

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185118	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/19/2016
NAME OF FACILITY SIGNATURE HEALTHCARE OF ELIZABETHTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 01/02/2016	ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 01/02/2016
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 01/02/2016	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 01/02/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>KT</i>	DATE <i>01/26/16</i>	SIGNATURE OF SURVEYOR <i>Nikki Zundstein</i>	DATE <i>1/26/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/19/2015

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO

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F 000	INITIAL COMMENTS AMENDED 01/06/16 A Recertification Survey was initiated on 11/16/15 and concluded on 11/19/15 and found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "F".	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 158 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged; and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.	F 158	F-156 1. Resident #15 and unsampled residents A and B are discharged residents and the charts are closed. Liability and appeal notices were sent via certified mail 12/21/2015 by the Business Office Manager for resident #15 and unsampled residents A and B to notify them of their benefits upon discharge from our facility. 2. All discharging residents have the potential to be affected. 3. Administrator provided education to the Business Office Manager 12/7/2015 by the means of presentation regarding Medicare non-coverage letters and understanding of Medicare requirements have been voiced. An audit was initiated by the Administrator 12/11/2015 and will be completed by the Administrator and/or Business Office Manager on all discharging residents to ensure compliance with Medicare non-coverage guidelines and to prevent recurrence of the deficient practice.	1/2/2016

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

[Signature]

TITLE (X6) DATE

X Admin RECEIVED 1/5/16

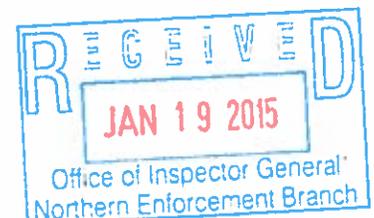
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Office of Inspector General
Northern Enforcement Branch

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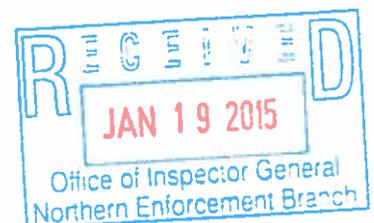
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F 156	<p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the</p>	F 156	<p>4. The Administrator and/or Business Office Manager will complete these audits weekly for three months then quarterly to ensure compliance with Medicare non-coverage guidelines. Results of this audit will be reported by the Business Office Manager and/or Administrator (at least monthly for 3 months and then quarterly) at the Performance Improvement Committee Meeting with follow up action or education as needed. The Performance Improvement Committee will meet at least monthly for three months and then at least quarterly thereafter to ensure continued compliance is achieved and/or maintained. The Performance Improvement Committee will determine the need to increase, decrease, or discontinue these audits based on the findings to ensure compliance. The Administrator is responsible for overall compliance.</p>		



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F 156	<p>Continued From page 2</p> <p>name, specially, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to provide Notice of Medicare Non-Coverage letters to one (1) of seventeen (17) sampled residents and two (2) of six (6) unsampled residents, Resident #15 and Unsampled Residents A and B.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Notice of Medicare Non-Coverage, dated 03/01/15, revealed the Notice of Medicare Non-Coverage would be delivered to all Medicare beneficiaries at least forty-eight (48) hours or two (2) days prior to anticipated termination of services. The Business Office Manager would deliver all Medicare notices of non-coverage, including those for Part B services which included Medicare B and Managed Medicare B.</p> <p>Review of Resident #15's clinical record revealed the facility discharged the resident home with</p>	F 156			



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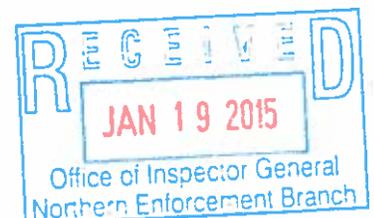
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F 156	Continued From page 3 Home Health Services, on 04/24/15, without issuing a liability and appeal notice. Review of Unsampled Resident A's clinical record revealed the facility discharged the resident, on 09/11/15, without issuing a liability and appeal notice. Review with the Business Office Manager revealed the resident had eighty (80) skilled days available. Review of Unsampled Resident B's clinical record revealed the facility discharged the resident, on 10/10/15, without issuing a liability and appeal notice. Review with the Business Office Manager revealed the resident had sixty-one (61) skilled days available. Interview with the Business Office Manager, on 11/19/15 at 4:25 PM, revealed she received training on the Medicare Beneficiary Notices through corporate and the training instructed she was not required to issue the notice letters if the resident went to the hospital or to the same level of care. She stated she did not have to issue the letter if the resident chose to leave the facility, even when they still had days available. She stated she did not issue the notice letters to Resident #15 or Unsampled Resident A, or B as they left on their own request for discharge. She stated she was not aware Resident #15 was discharged with Home Health Services. Interview with the Administrator, on 11/19/15 at 5:00 PM, revealed the Regional Level Support instructed him and the Business Office Manager they were not required to provide the letters to residents leaving the facility on their own request.	F 156			
F 164	483.10(e), 483.75(l)(4) PERSONAL	F 164			

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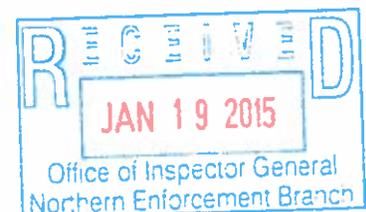
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F 164 SS=D	<p>Continued From page 4</p> <p>PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide privacy during medical treatments for two (2) of six (6) unsampled residents, (Unsampled Resident D and E). Unit Manager #1 and LPN #2</p>	F 164	<p>F-164</p> <ol style="list-style-type: none"> 1. The Director of Nursing-RN re-educated Unit Manager #1 and LPN #2 on 11/17/2015 on privacy that is required to be given during resident's medical treatment by the means of presentation. 2. Any resident that received medical treatment by Unit Manager #1 or LPN #2 on 11/17/2015 prior to the re-education provided by the Director of Nursing-RN on 11/17/2015 had the potential to be affected. 3. Staff Development Coordinator-RN provided re-education to all Nursing Staff on 12/7/2015 and 12/8/2015 regarding privacy that is required during medical treatment by the means of presentation. <p>Education will be on going by the means of presentation until all nursing staff has attended. No nursing staff will be allowed to work without having been in serviced. The facility does not employ agency staff, however if the facility should employ agency staff, the agency staff will receive the in service prior to working.</p> <p>This education by the means of presentation will be added to general orientation for all nursing staff that should be hired.</p>	1/2/2016



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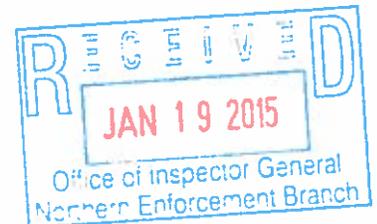
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F 164	<p>Continued From page 5 administered insulin by injection to Unsampled Resident D and E without providing privacy.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding resident privacy.</p> <p>Observation of Unsampled Resident D, on 11/17/15 at 11:05 AM, revealed Unit Manager #1 administered Humalog Insulin into Unsampled Resident D's abdomen exposing his/her abdomen in the hallway.</p> <p>Interview with Unit Manager #1, on 11/19/15 at 2:08 PM, revealed she was not aware she provided insulin to Unsampled Resident D in the hallway. The Unit Manager #1 stated the staff was not to provide care in the hallway because of privacy.</p> <p>Observation of Unsampled Resident E, on 11/18/15 at 11:40 AM, revealed Licensed Practical Nurse (LPN) #2 administered Humalog Insulin to Unsampled Resident E's right thigh. Unsampled Resident E was observed lying down in bed in his/her room and the curtain was not pulled around the bed for privacy. Unsampled Resident E's roommate was in the next bed over while Unsampled Resident E's right thigh was exposed.</p> <p>Interview with Unsampled Resident E, on 11/18/15 at 11:45 AM, revealed it did not bother him/her to have his/her thigh exposed, and stated his/her roommate was family.</p> <p>Interview with LPN #2, on 11/18/15 at 11:42 AM, revealed she should have pulled Unsampled</p>	F 164	<p>An audit was initiated by the Staff Development Coordinator-RN on 12/11/2015 to ensure required privacy is provided to residents during medical treatment. The Director of Nursing-RN and/or Staff Development Coordinator-RN will observe at least 3 nursing staff while providing care with each audit to ensure privacy is given during care to prevent recurrence of the deficient practice.</p> <p>4. The Director of Nursing-RN and/or Staff Development Coordinator-RN will complete these audits weekly for three months then quarterly to ensure the required privacy is provided to residents during medical treatment. Results of this audit will be reported by the Staff Development Coordinator-RN (at least monthly for 3 months then quarterly) at the Performance Improvement Committee Meeting with follow up action or education as needed. The Performance Improvement Committee will meet at least monthly for three months and then at least quarterly thereafter to ensure continued compliance is achieved and/or maintained. The Performance Improvement Committee will determine the need to increase, decrease, or discontinue these audits based on the findings to ensure compliance. The Administrator is responsible for overall compliance.</p>	



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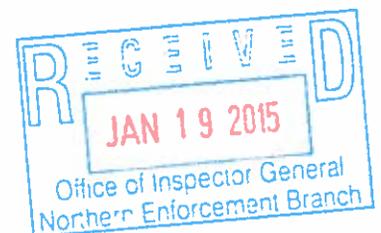
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F 164	Continued From page 6 Resident E's curtain for privacy.	F 164		
F 282 SS=D	<p>Interview with the Director of Nursing (DON), on 11/19/16 at 2:52 PM, revealed she wanted staff to provide privacy while doing care because it was the resident's right to have privacy.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, Interview, record review and facility policy review, it was determined the facility failed to follow care plans for one (1) of seventeen (17) sampled residents, Resident #8). The Minimum Data Set (MDS) Coordinator failed to remove the lap buddy for Resident #8 during a meal as care planned.</p> <p>The findings include: Review of the Care Plan Policy, reviewed by the facility on 06/01/15, revealed an individualized comprehensive care plan included measurable objectives and timetables to meet the resident's medical and psychological needs. The care plan interventions would be implemented after consideration of the resident's problem areas and their causes. Review of Resident #8's medical record revealed the facility admitted the resident on 04/30/15 with</p>	F 282	<p>F-282</p> <ol style="list-style-type: none"> 1. IDT met and the Lap Buddy for Resident #6 was discontinued per Physicians order and resident's plan of care was updated on 12/10/2015. 2. Director of Nursing-RN completed a complete audit for all residents 11/17/2015 to ensure all services were being provided by qualified persons in accordance with each resident's written plan of care. <p>No others residents were affected by this deficient practice.</p> <ol style="list-style-type: none"> 3. Staff Development Coordinator-RN provided re-education to all Nursing Staff on 12/7/2015 and 12/8/2015 that all care provided has to be in accordance with each residents written plan of care by the means of presentation. Education will be on going by the means of presentation until all nursing staff has attended. No nursing staff will be allowed to work without having been in serviced. The facility does not employ agency staff, however if the facility should employ agency staff, the agency staff will receive the in service prior to working. This education by the means of presentation will be added to general orientation for all nursing staff that should be hired. 	1/2/2016



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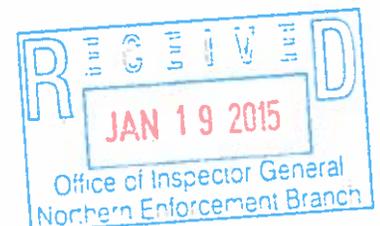
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F 282	<p>Continued From page 7</p> <p>diagnoses of Adult Failure to Thrive, Altered Mental Status, Difficulty Walking, Osteoporosis, Abnormal Posture and Muscle Weakness.</p> <p>Review of Resident #6's Minimum Data Set (MDS) Quarterly Assessment, dated 08/27/15, revealed the facility assessed Resident #6 with a Brief Interview for Mental Status (BIMS) score of three (3) which meant Resident #6 was not interviewable.</p> <p>Review of Resident #6's Physical Restraint Use care plan, dated 08/11/15, revealed the staff was to provide Resident #6 with a lap buddy to his/her wheelchair to aide in positioning while in wheelchair. The lap buddy was to be released every two (2) hours and at meal times.</p> <p>Observation of Resident #6 during the breakfast meal, on 11/17/15 at 8:40 AM, revealed the MDS Coordinator assisted Resident #6 with eating his/her breakfast meal. Resident #6 was sitting up in a high back wheelchair with the lap buddy over their lap.</p> <p>Interview with the MDS Coordinator, on 11/19/15 at 2:35 PM, revealed the admitting nurse normally completed the interim care plan. The MDS Coordinator completed the full assessment care plan. The MDS Coordinator stated the staff was expected to follow the care plan and she was aware Resident #6's lap buddy was to be removed. The MDS Coordinator stated she was nervous and forgot to remove Resident #6's lap buddy.</p> <p>Interview with Unit Manager #1, on 11/19/15 at 2:08 PM, revealed she expected the staff to follow the care plan. Unit Manager #1 stated</p>	F 282	<p>An audit was initiated by the Staff Development Coordinator-RN 12/11/2015 to ensure that all care provided is in accordance with each residents written plan of care. The Director of Nursing-RN and/or Staff Development Coordinator-RN will observe at least 3 nursing staff will providing care to ensure the care that is being provided is based on the residents care plan</p> <p>4. The Director of Nursing-RN and/or Staff Development Coordinator-RN will complete these audits weekly for three months then quarterly to ensure that all care provided is in accordance with each resident's written plan of care. Results of this audit will be reported by the Staff Development Coordinator-RN (at least monthly for 3 months the quarterly) at the Performance Improvement Committee Meeting with follow up action or education as needed. The Performance Improvement Committee will meet at least monthly for three months and then at least quarterly thereafter to ensure continued compliance is achieved and/or maintained.</p> <p>The Performance Improvement Committee will determine the need to increase, decrease, or discontinue these audits based on the findings to ensure compliance. The Administrator is responsible for overall compliance.</p>		



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

PRINTED: 01/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 8 normally the nursing staff removed the lap buddy when Resident #6 was eating. The Unit Manager stated the lap buddy was present just for positioning. Interview with the Director of Nursing (DON), on 11/19/15 at 2:52 PM, revealed she expected the staff to follow the care plan as it related to removing Resident #6's lap buddy when he/she ate. The DON stated the MDS Coordinator informed the DON that she had not removed Resident #6's lap buddy during the meal.	F 282		1/2/2016	
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 observation, interview, record review and policy review, it was determined the facility failed to follow physician orders for one (1) of seventeen (17) sampled residents (Resident #8). The Minimum Data Set (MDS) Coordinator failed to remove a lap buddy during a meal for Resident #8 as ordered by the physician. The findings include:	F 309	F-309 1. IDT met and the Lap Buddy for Resident #6 was discontinued per Physicians order and resident's plan of care was updated on 12/10/2015. 2. Director of Nursing-RN completed a complete audit for all residents 11/17/2015 to ensure each resident was receiving and that the facility was providing 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 to include following physician orders. No others residents were affected by this deficient practice. 3. Staff Development Coordinator-RN provided re-education to all Nursing Staff on 12/7/2015 and 12/8/2015 that each resident must receive and that 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 to include following physician orders by the means of presentation.		



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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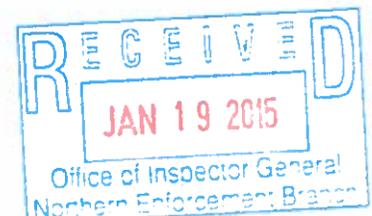
PRINTED: 01/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 9</p> <p>The facility did not provide a policy regarding following physician orders.</p> <p>Review of Resident #6's medical record revealed the facility admitted the resident on 04/30/15 with diagnoses of Adult Failure to Thrive, Altered Mental Status, Difficulty Walking, Osteoporosis, Abnormal Posture and Muscle Weakness.</p> <p>Review of Resident #6's Minimum Data Set (MDS) Quarterly Assessment, dated 08/27/15, revealed the facility assessed Resident #6 with a Brief Interview for Mental Status (BIMS) score of three (3) which meant Resident #6 was not interviewable.</p> <p>Review of Resident #6's Physician Orders, for the month of November 2015, revealed Resident #6 had an order to utilize a Lap Buddy to the wheelchair when out of bed. The Lap Buddy was to be released every two (2) hours and with meals to aid in positioning and safety related to general weakness.</p> <p>Observation of Resident #6 during the breakfast meal, on 11/17/15 at 8:40 AM, revealed Resident #6 was sitting up in a high back wheelchair with a lap buddy over their lap and connected to the wheelchair arms. Resident #6 was eating a mechanical soft diet with the MDS Coordinators assistance.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 11/19/15 at 2:27 PM, revealed when Resident #6 sat to eat a meal the staff were to take off the lap tray.</p> <p>Interview with the MDS Coordinator, on 11/19/15 2:35 PM, revealed she was aware Resident #6's</p>	F 309	<p>Education will be on going by the means of presentation until all nursing staff has attended. No nursing staff will be allowed to work without having been in serviced. The facility does not employ agency staff, however if the facility should employ agency staff, the agency staff will receive the in service prior to working. This education by the means of presentation will be added to general orientation for all nursing staff that should be hired.</p> <p>An audit was initiated by the Staff Development Coordinator-RN 12/11/2015 to ensure each resident receives and that the facility provides 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 to include following physician orders. These audits will prevent recurrence of the deficient practice.</p> <p>4. The Director of Nursing-RN and/or Staff Development Coordinator-RN will complete these audits weekly for three months then quarterly to ensure each resident receives and that the facility provides 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 to include following physician orders. Results of this audit will be reported by the Staff Development Coordinator-RN (at least monthly for 3</p>		

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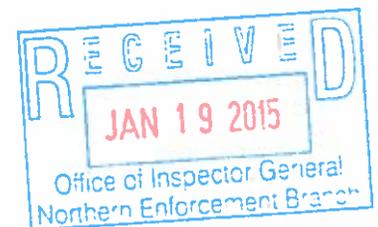
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 10 restraint was to be removed at meals, but she was nervous and forgot to remove the restraint. The lap tray was used by Resident #8 to help with positioning. Interview with the Director of Nursing (DON), on 11/19/15 at 2:52 PM, revealed Resident #8 had a problem with leaning over in his/her wheelchair and the lap buddy was ordered for positioning. The DON stated the lab buddy was to be removed at meals so the resident could receive a break from the positioning device.	F 309	months then quarterly) at the Performance Improvement Committee Meeting with follow up action or education as needed. The Performance Improvement Committee will meet at least monthly for three months and then at least quarterly thereafter, to monitor and ensure continued compliance is achieved and/or maintained. The Performance Improvement Committee will determine the need to increase, decrease, or discontinue these audits based on the findings to ensure compliance. The Administrator is responsible for overall compliance.		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the Dietary staff failed to ensure equipment was clean when used for twenty-five (25) of thirty-two (32) dish racks and one (1) of one (1) doors in good repair. In addition, the door to the dish wash room was in disrepair. The maroon colored panel was loosely attached to the door.	F 371	F-371 1. Dietary Manger placed an order for new dish racks on 12/3/2015; all dish racks cited by this deficient practice will be replaced with new dish racks by 1/2/2016. The door to the dish wash room that was found in disrepair was replaced by the Director of Environmental Services on 12/9/2015 2. Dietary Manager completed an audit of the entire kitchen 12/9/2015 to ensure the facility was storing, preparing, and distributing food under sanitary conditions, no other concerns were identified. All residents have the potential to be affected by this practice.	1/2/2016	



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: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 The findings include: Review of the facility's policy regarding Cleaning and Sanitizing Dietary Areas and Equipment, not dated, revealed all kitchen areas and equipment would be maintained in a sanitary manner and be free of build up of food, grease, or other soil. The facility would provide sanitary food service that met state and federal regulations. Review of the policy revealed a cleaning schedule was attached that stated the staff was to delime the dish racks monthly on the third (3rd) Monday. Observation of the dishroom during tour, on 11/16/15 at 2:16 PM, revealed there were eighteen (18) dish racks in the dish area. Observation of the dishroom, on 11/18/15 at 12:50 PM, revealed there were twenty-five (25) dish racks in the dish and kitchen area. Observation of the dishroom, on 11/19/15 at 2:45 PM, revealed the twenty-five (25) dish racks were in the dish and kitchen area. The dish racks revealed textured sides with a black substance in the textured areas. The inside of the dish racks in the area where the dishes rested revealed a black and white build up in the crevices. Observation, on 11/17/15 at 2:29 PM, revealed the kitchen entry door had a maroon colored panel on the lower portion of the door that had the edges rolled back and was loose on three sides. There were six (6) screws across the top holding the panel in place. Interview with the Director of Dietary, on 11/19/15 at 2:45 PM and at 4:45 PM, revealed the policy for a cleaning schedule was in place when she arrived to this position several months ago;	F 371	3. Administrator educated Dietary Manager on 11/19/2015 by means of presentation on the policy for a cleaning schedule. Staff Development Coordinator-RN provided re-education to all Staff on 12/7/2015 and 12/8/2015 that the facility must store, prepare, distribute and serve food under sanitary conditions by the means of presentation. Education will be on going by the means of presentation until all staff has attended. No staff will be allowed to work without having been in serviced. The facility does not employ agency staff, however if the facility should employ agency staff, the agency staff will receive the in service prior to working. This education by the means of presentation will be added to general orientation for all staff that should be hired. 4. The Administrator and/or Dietary Manager will complete kitchen audits weekly for three months then quarterly to ensure the facility is storing, preparing, distributing, and serving food under sanitary conditions. Results of this audit will be reported by the Dietary Manager (at least monthly for 3 months then quarterly) at the Performance Improvement Committee Meeting with follow up action or education as needed. The Performance Improvement Committee will meet at least monthly for	



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

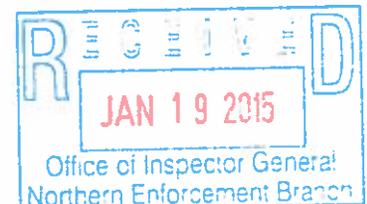
PRINTED: 01/08/2016
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 12 however, the schedule was not initiated by her after becoming the Director of the department. She stated the cleaning schedule was not maintained; therefore, there was a breakdown in the cleaning process for the department. She stated it was believed some of the dishracks were probably some of the original. She stated twenty-five (25) of the thirty-two (32) dish racks had a black and white substance in the crevices and on the textured surface of the dish racks. She stated the size of the panel covering the door was thirty-six inches by thirty inches (36" x 30") and had six (6) screws across the top area to hold the panel on the door with the other sides loosely attached. Interview with the Administrator, on 11/19/15 at 3:10 PM, revealed the dish racks were not acceptable. He stated he was in the kitchen and dishroom areas at least weekly; however, had not noticed the black and white substance on the racks. He stated he was not aware the cleaning schedule was not utilized in the kitchen area.	F 371	three months and then at least quarterly thereafter to ensure continued compliance is achieved and/or maintained. The Performance Improvement Committee will determine the need to increase, decrease, or discontinue these audits based on the findings to ensure compliance. The Administrator is responsible for overall compliance.		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide a sanitary environment for residents, staff and the public at one (1) of one (1) rear entrance	F 465	F-465 1. The full bag of garbage (was properly disposed of 11/16/2015), a soiled glove, and discarded chairs to the immediate left of the rear entrance to the facility from the parking lot were properly disposed of 11/17/2015 2. All residents have the potential to be affected by this practice. 3. Administrator re-educated the Director of Environmental Services 11/17/2015 that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and public by means of presentation. Staff Development Coordinator-RN provided re-education to all Staff on 12/7/2015 and 12/8/2015 that the facility	1/2/2016	

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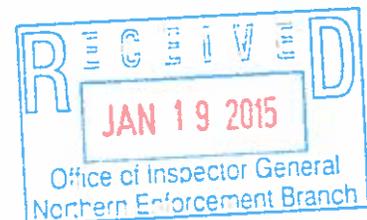
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 465	<p>Continued From page 13</p> <p>doors. The staff left a full bag of garbage, a soiled glove and discarded chairs to the immediate left of the rear entrance to the facility from the parking lot.</p> <p>The findings include:</p> <p>The facility did not provide a policy specific to sanitation and garbage disposal.</p> <p>Observation during the initial environmental tour, on 11/16/15 at 2:10 PM, revealed a full garbage bag, one (1) soiled glove and two (2) cloth chairs left of the rear entrance to the facility. The rear entrance served as the main entrance to the facility from the parking lot. It was raining upon entry and both chairs were soaked through with rain.</p> <p>Observation of the rear entrance, on 11/16/15 at 4:30 PM, revealed the garbage had been removed, but the glove and chairs remained. It continued to rain and soak the chairs.</p> <p>Observation of the rear entrance, on 11/17/15 at 8:00 AM, revealed a single soiled glove remained on the ground and a third (3) cloth chair was now sitting at the entrance and being soaked through from rain.</p> <p>Observation, on 11/19/15 at 4:30 PM, revealed the glove and the three (3) chairs had all been removed from the entrance.</p>	F 465	<p>presentation.</p> <p>Education will be on going by the means of presentation until all staff has attended. No staff will be allowed to work without having been in serviced. The facility does not employ agency staff, however if the facility should employ agency staff, the agency staff will receive the in service prior to working. This education by the means of presentation will be added to general orientation for all staff that should be hired.</p> <p>An audit was initiated by the Director of Environmental Services 12/11/2015 to ensure the facility is providing a safe, functional, sanitary, and comfortable environment for residents, staff and publics. These audits will prevent recurrence of the deficient practice,</p> <p>4. The Administrator and/or Director of Environmental Services will complete an Environmental Conditions Audit weekly for three months then quarterly to ensure the facility is providing a safe, functional, sanitary, and comfortable environment for residents, staff and publics. Results of this audit will be reported by the Dietary Manager (at least monthly for 3 months then quarterly) at the Performance Improvement Committee Meeting with follow up action or education as needed. The Performance Improvement Committee will meet at least monthly for three months and then at least quarterly thereafter to ensure continued compliance is achieved and/or maintained.</p>		



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: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 465	Continued From page 14 Interview with Housekeeping, on 11/19/15 at 3:20 PM, revealed the garbage was to remain in the housekeeping carts until emptied and taken directly to the dumpster. The laundry area and the location of the housekeeping carts were to be kept a clean area free of debris and garbage. Interview with the Director of Environmental Services, on 11/19/15 at 3:30 PM, revealed staff sometimes set the garbage outside the laundry room door, which was directly left of the entrance to go back in and retrieve broken down boxes, but he would never expect garbage to be sitting longer than ten (10) minutes or so. Interview with the Director of Nursing, on 11/19/15 at 3:00 PM, revealed garbage was to be taken directly to the dumpster. She reported occasionally seeing a stray glove here and there. She also explained that the three (3) chairs were placed near the entrance and she had instructed staff to wait until the chairs were dry before taking them to the dumpster.	F 465	The Performance Improvement Committee will determine the need to increase, decrease, or discontinue these audits based on the findings to ensure compliance. The Administrator is responsible for overall compliance.		



**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER K1 185118	FACILITY NAME SIGNATURE HEALTHCARE OF ELIZABETHTOWN	SURVEY DATE *K4 11/18/2015
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K6 DATE OF PLAN APPROVAL	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u> 1 </u> NUMBER OF THIS BUILDING <u> 01 </u>	<input checked="" type="checkbox"/> A A BUILDING B WING C FLOOR D APARTMENT UNIT
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LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

***K7** 12 SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: 1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: 4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: 7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: e.g 2.5

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: 3 **K56:** 3

***K9 : FACILITY MEETS LSC BASED ON: (Check all that apply)**

A1 <input type="checkbox"/>	A2 <input checked="" type="checkbox"/>	A3 <input type="checkbox"/>	A4 <input type="checkbox"/>	A5 <input type="checkbox"/>
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: A. <input checked="" type="checkbox"/> FULLY SPRINKLERED (All required areas are sprinklered) B. <input type="checkbox"/> PARTIALLY SPRINKLERED (Not all required areas are sprinklered) C. <input type="checkbox"/> NONE (No sprinkler system)
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***MANDATORY**

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: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 12/21/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS	{K 000}			
	Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/12/15 as alleged.				

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.

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185118	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 12/21/2015
NAME OF FACILITY SIGNATURE HEALTHCARE OF ELIZABETHTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # NFPA 101 LSC K0029	Correction Completed 12/12/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0050	Correction Completed 12/12/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>YH</i>	DATE <i>01/26/15</i>	SIGNATURE OF SURVEYOR <i>Melie Zimmerman</i>	DATE <i>1/26/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/18/2015

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO

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

PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II, 500 KW (Installed in 2009).</p> <p>A Recertification Life Safety Code Survey was conducted on 11/18/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest</p>	K 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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

TITLE

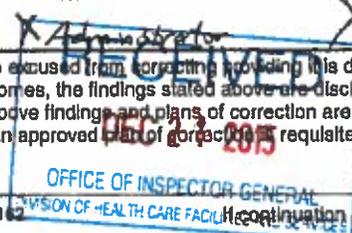
(X6) DATE

X *Martin*

X *Administrator*

X 12-21-15

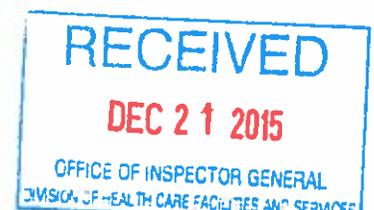
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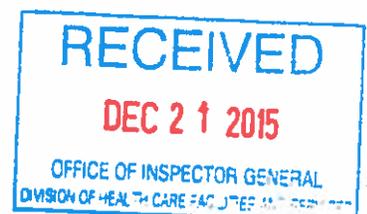
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ELIZABETHTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
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K 000 K 029 SS=D	Continued From page 1 deficiency at F level. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has one-hundred and twelve (112) certified beds and the census was eighty-four (84) on the day of the survey. The findings include: Observation, on 11/17/15 at 2:53 PM, with the Regional Plant Operational Director and the Plant Director revealed the door to the Central Supply Storage Room was not equipped with a	K 000 K 029	K-029 1. Administrator provided education to the Director of Environmental Services on 11/20/15 about K-029 requirements, cited deficiency, corrective action and preventative measures by way of presentation to assure that all hazardous locations are substantially compliant at all times: to include self-closing devices on doors where required. 2. Director of Environmental Services installed a self-closing device on door to the Central Supply Storage Room on 11/27/15. No other doors were affected. 3. All doors inspected by Director of Environmental Services by 12/11/15 for substantial compliance with K-029; including use of self-closing devices where required. 4. The Director of Environmental Services will complete environmental audits weekly for three months then quarterly to ensure the facility is protecting from hazards. Results of this audit will be reported by the Director of Environmental Services (at least monthly for 3 months then quarterly) at the Performance Improvement Committee Meeting with follow up action or education as needed. The Performance Improvement Committee will meet at	12/12/2015



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K 029	<p>Continued From page 2 self-closing device.</p> <p>Interview, on 11/17/15 at 2:55 PM, with the Regional Plant Operational Director and the Plant Director revealed the room had recently been converted to a storage room and had previously been used as a Family Room, not requiring a self-closing device.</p> <p>The census of eighty-four (84) was verified by the Administrator, on 11/17/15. The findings were acknowledged by the Administrator and verified by the Regional Plant Operational Director and the Plant Director at the exit interview on 11/17/15.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), 	K 029	<p>least monthly for three months and then at least quarterly thereafter to ensure continued compliance is achieved and/or maintained. The Performance Improvement Committee will determine the need to increase, decrease, or discontinue these audits based on the findings to ensure compliance. The Administrator is responsible for overall compliance.</p>	

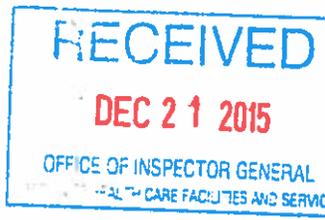


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K 029	Continued From page 3 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the five (5) smoke compartments, residents, staff, and visitors. The facility has one-hundred and twelve (112) certified beds and the census was	K 050	K-050 1. Administrator provided education to the Director of Environmental Services on 11/20/15 about K-050 requirements, cited deficiency, corrective action and preventative measures by way of presentation to assure that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. 2. All residents have the potential to have been affected. 3. Director of Environmental Services will hold and document fire drills quarterly on each shift at random times. 4. Times and results of these drills will be reported by the Director of Environmental Services (at least monthly for 3 months then quarterly) at the Performance Improvement Committee Meeting with follow up action or education as needed.	12/12/2015



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K 050	Continued From page 4 eighty-four (84) on the day of the survey. The findings include: Review of the facility's fire drill records, on 11/17/15 at 10:29 AM, with the Regional Plant Operational Director revealed the facility had been conducting fire drills at a minimum of one (1) per shift per quarter, but not at random times during the third shift. Interview, on 11/17/15 at 10:31 AM, with the Regional Plant Operational Director revealed the facility had a change in maintenance personnel at the end of the first quarter of 2015 and acknowledged that the fire drills conducted during the third shift were not conducted at random times. The Regional Plant Operational Director stated the fire drills were conducted within the permitted one (1) hour time frame both before and after the previously conducted fire drill. The census of eighty-four (84) was verified by the Administrator on 11/17/15. The findings were acknowledged by the Administrator and verified by the Regional Plant Operational Director and Plant Director at the exit interview on 11/17/15. Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	The Performance Improvement Committee will meet at least monthly for three months and then at least quarterly thereafter to ensure continued compliance is achieved and/or maintained. The Performance Improvement Committee will determine the need to adjust drill times based on the findings to ensure compliance. The Administrator is responsible for overall compliance.	

