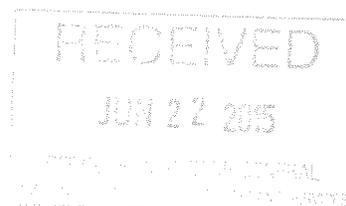


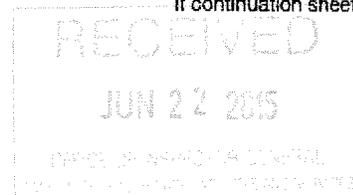
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2015
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
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F 441	<p>Continued From page 46</p> <p>Review of the medical record for Resident #3 revealed the facility admitted the resident on 12/15/14 with Diagnosis including Dementia without behaviors, Anxiety and Hearing Loss.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #3, dated 04/16/15, revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status (BIMS) assessment. The facility assessed the residents BIMS score of three (3) of fifteen (15), severely cognitively impaired. The facility assessed the resident's bowel and bladder as always incontinent.</p> <p>Review of the Comprehensive Care Plan for Resident #3 revealed the facility developed a care plan on 01/26/15 for Potential for impaired skin. Interventions included incontinent care as needed and barrier cream as indicated.</p> <p>Observation, on 05/21/15 at 1:15 PM, revealed Certified Nursing Assistant (CNA) #2 applied barrier cream for Resident #3, after incontinent care, on the buttocks area then went on to apply the cream to the genital area.</p> <p>Interview, on 05/22/15 at 12:27 PM, with CNA #2 revealed she acknowledged she should have applied the barrier cream to the genital area first then to the buttocks area. She stated there was a potential for cross contamination for the resident.</p> <p>Interview, on 05/22/15 at 12:33 PM, with Licensed Practical Nurse (LPN) #2 revealed she observed CNA #2's improper application of the barrier cream for Resident #3 when she went from the back to the front but didn't think she could stop her. She stated the risk to the resident was</p>	F 441	<p>of hand hygiene with return demonstration; prevention and early interventions steps regarding hand hygiene; contact precautions for isolation as it relates to infection control and the policy on clostridium difficile. This was completed by 5/20/2015.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>Nursing Administration (Director of Nursing, Assistant Director of Nursing, and/or Nurse Unit Managers) will complete 5 monthly audits for peri-care return demonstration on nursing assistants. Any problems identified will be addressed immediately and will be documented on the audit tool. This will be effective for 6/18/2015.</p> <p>Nursing Administration (Director of Nursing, Assistant Director of Nursing, and/or Nurse Unit Managers) completed education/training to departmental managers and other staff regarding infection control with isolation contact precautions, that included c-diff. This was completed by 6/18/2015.</p> <p>Nursing Administration (Director of Nursing, Assistant Director of Nursing, and/or Nurse Unit Managers) will complete 5 monthly audits to ensure that staff aware and are practicing good infection control</p>	



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F 441	<p>Continued From page 47 contamination.</p> <p>Interview, on 05/22/15 at 3:30 PM, with the Assistant Director of Nursing (ADON) revealed she was the infection control nurse. She stated the last training on Peri Care included application of barrier creams. She stated staff were trained to wash and apply creams to the peri area from front to back. She stated the risk to the resident was the spread of infection due to infection control breaches.</p> <p>2. Review of the facility policy, Clostridium Difficile (C-Diff), dated February 2014, revealed preventative measures will be taken to prevent transmission of C-Diff to others. C-Diff spores can persist on resident-care items and surfaces for several months and are resistant to common cleaning and disinfection methods. Healthcare workers and visitors will wear gloves and gowns when entering the room of a resident with C-Diff infections and wash hands with soap and water upon exiting the room.</p> <p>Review of the clinical record for Resident #7, revealed the resident was admitted to the facility, on 03/24/15 with the diagnoses of Congestive Heart Failure, Chronic Airway obstruction, Hypertension, Cerebrovascular Accident, and Viral Pneumonia. Further review of the record revealed the resident was put in contact isolation for C-Diff on 05/18/15.</p> <p>Review of the Comprehensive Care Plan for Resident #7, dated 05/18/15, revealed the facility developed a care plan for C-Diff infection with interventions including isolation per Centers for Disease Control (CDC).</p>	F 441	<p>with residents that are in isolation contact precautions. Any problems identified will be addressed immediately and will be documented on the audit tool. This will be effective for 6/18/2015.</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation included the following:</p> <p>Administrator will review the monthly peri-care audits and will analyze for any patterns and trends and will report to the facility (PI) Quality Committee. This will be effective for the June 2015 meeting.</p> <p>Administrator will review the monthly infection control/isolation contact precaution audits and will analyze for any patterns and trends and will report to the facility (PI) Quality Committee. This will be effective for the June 2015 meeting.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue</p>		



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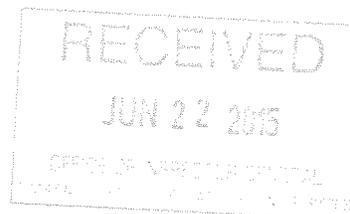
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F 441	<p>Continued From page 48</p> <p>Review of Staff in-services dated 03/17/15 revealed staff had been trained on C-Diff precautions including the Social Services Director.</p> <p>Observation of Resident #7, on 05/19/15 at 2:35 PM, revealed Personal Protective Equipment (PPE) hanging on the front of the resident's door. The resident was in the room lying in bed. The Social Services Director (SSD) was beside the resident's bed, sitting in the resident's wheelchair conversing with the resident. The SSD was not wearing any PPE.</p> <p>Continued observation of Resident #7, on 05/19/15 at 2:45 PM, revealed the SSD exited the resident's room without washing her hands.</p> <p>Interview with the SSD, on 05/19/15 at 2:45 PM, revealed she knew Resident #7 was in isolation for C-Diff and PPE was to be worn while in the resident's room. The SSD stated she forgot to put on the PPE and wash her hands. The SSD further stated by not wearing the appropriate PPE and washing her hands, the spread of infection to other residents could occur. She stated she had attended in-services on infection control and hand hygiene.</p> <p>Interview, on 05/22/15 at 3:30 PM, with the Assistant Director of Nursing (ADON), revealed she was the infection control nurse. She stated the SSD was very passionate about her work and was just focusing on the resident when she breached isolation precautions. She stated staff had been trained on isolation precautions.</p>	F 441	<p>monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514	F514 SS=D Completion Date: 6/19/2015	



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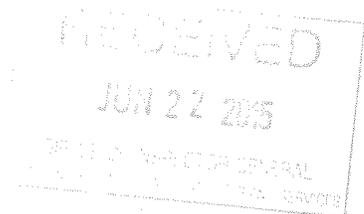
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F 514	<p>Continued From page 49 LE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure medical records were complete and accurate for three (3) of sixteen (16) sampled residents (Residents #6, #8 and #9). Staff documented another residents information into Resident #8's medical record and was unable to complete Resident #8's restraint assessment completely. In addition, Resident #6 and #9's alarm checks could not be printed or reviewed by staff to ensure the alarm checks were being completed daily.</p> <p>The findings include: No Policy could be provided.</p> <p>1. Record review of Resident #8's clinical record, revealed Resident #8 was admitted on 07/01/12</p>	F 514	<p>Records-Complete/Accurate/Accessible</p> <p>The specific residents that were cited in the statement of deficiency as having been affected were as follows: Resident #s 6, 8, and 9.</p> <p>Resident #s 6 and 9 were issues with having no documentation in the medical record regarding nursing staff checking the placement and functioning of alarms that had been identified as fall interventions. Director of Nursing ensured that this was indicated on the current treatment administration records for these residents and that nursing staff were educated/trained to complete this task, as outlined on the treatment administration records. This was completed by 6/18/2015.</p> <p>Resident # 8 was the issue that in the electronic medical record for this resident, in a nursing notes, documentation had been entered in error because the information was pertaining to another resident. Assistant Director of Nursing corrected this error on 6/8/2015.</p> <p>All residents have a potential to be affected by this deficient practices, and on the first day of the survey the facility census was at 57.</p> <p>Director of Nursing reviewed the residents that had fall interventions for alarms that were to be checked for functioning and</p>		



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F 514	<p>Continued From page 50</p> <p>with a diagnosis of Asphasia, Quadriplegia, Spasm of Muscle, Non Psychotic Brain Syndrome and Pain of the Joint. Resident #8's Quarterly Minimum Data Set (MDS) Assessment, completed on 05/05/15, revealed Resident #8's Brief Interview of Mental Status (BIMS) score could not be assessed, which meant Resident #8 was not interviewable. Resident #8 was care planned to be a two (2) person assist with the Hoyer lift.</p> <p>Observation of Resident #8, on 05/19/15 at 12:00 PM, revealed Resident #8 was sitting up in wheelchair. Both of Resident #8's arms were observed to be contracted.</p> <p>Observation of Resident #8, on 05/20/15 at 7:52 AM, revealed Resident #8 sitting up in wheelchair in the television room. Both hands were observed in splints and the residents feet were elevated in Una boots.</p> <p>Review of Resident #8's Nursing Notes written by the Assistant Director of Nursing (ADON), on 02/24/15 at 12:01 PM, revealed Quarterly Care Plan Meeting was held. Resident in attendance and participated with entire discussion. Resident was concerned over getting an appointment with Medical Director (MD) regarding releasing muscle of left leg. The resident had been seen by the MD previously and was told he could possibly be able to walk again with the release of muscle in left leg. Currently awaiting return call from MD office to arrange appointment. Resident was very anxious regarding this issue. Discussed that the resident had a change in medication related to insomnia. The recent change had helped the resident with sleep.</p>	F 514	<p>placement by nursing staff and ensured this was a task that was placed on the appropriate residents' treatment administration records. This was completed by 6/18/2015.</p> <p>The active resident electronic medical records were reviewed by Nurse Administration (Director of Nursing, Assistant Director of Nursing, Nurse Unit Managers, and/or LPN MDS Coordinator) to ensure no other error like this had happened. No others were found with this audit. This was completed by 6/18/2015.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>Nursing Administration (Director of Nursing, Assistant Director of Nursing, and/or Nurse Unit Managers) revised the process that when nursing staff are responsible for checking the function and placement of alarms that have been used for fall interventions that the task will be indicated and documented on the appropriate resident's treatment administration record. This will provide evidence of documentation and compliance with this intervention. This was effective for 6/18/2015.</p> <p>Nursing Administration (Director of Nursing, Assistant Director of Nursing,</p>		



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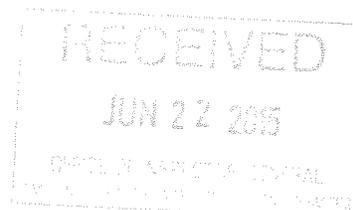
F 514	<p>Continued From page 51</p> <p>Interview with the ADON, on 05/22/15 at 4:50 PM, revealed she remembered writing the nursing note, but meant for the note to be in another residents record. The ADON stated she should have caught the name of the resident before she starting writing the note. The ADON stated the nursing note entry was not accurate to Resident #8 and she was not aware that she had charted on the wrong person.</p> <p>Observation of Resident #8, on 05/20/15 at 7:52 AM, revealed Resident #8 had a lap belt while sitting up in the wheelchair.</p> <p>Review of Resident #8's Safety Device Assessment, dated 05/15/15, revealed when asked what does this enable/restraint enable resident to do? The ADON responded "define boundaries; keeps resident from s".</p> <p>Interview with the ADON, on 05/22/15 at 4:50 PM, revealed the Safety Device Assessment was completed in the AHT (medical record). Further interview with the ADON, on 05/21/15 at 11:17 AM, revealed she thought when she typed onto the AHT system that the system would let her continue to type. The ADON stated "s" meant sliding. The ADON stated she could not say if the staff members would understand what "s" meant if she was not in the facility to explain. The ADON stated she would not say Resident #8's assessment was complete if there was not enough information documented. The ADON stated she was not aware the AHT system would not allow her to type but so far in the system.</p> <p>Interview with the Administrator, on 05/22/15 at 5:26 PM, revealed she was not aware the computer system was not letting staff provide</p>	F 514	<p>and/or Nurse Unit Managers) provided education/training to the nursing staff regarding their responsibility with performing the tasks of checking the placement and functioning of alarms and documenting this on the appropriate residents' treatment administration records as indicated. This was completed by 6/18/2015.</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation in relation to resident advanced directives and code status:</p> <p>Nursing Administration (Director of Nursing, Assistant Director of Nursing, and/or Nurse Unit Managers) will complete monthly audits of 5 residents' treatment administration records to ensure that nursing staff are documenting appropriately for checking the placement and functioning of alarms for fall interventions. Audit report will be completed that documents what was audited and the findings and any corrections or actions that were necessary. This will be effective for 6/18/2015.</p> <p>The Director of Nursing will report audit findings to the facility (PI) Quality Committee. This will be effective for the June 2015 meeting.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality</p>	
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APPROVED
JUN 22 2015
DIRECTOR OF NURSING
ELIZABETHTOWN NURSING AND REHABILITATION CENTER

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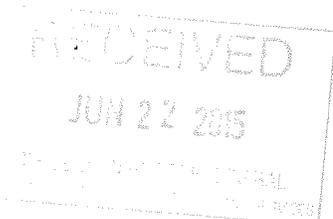
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F 514	<p>Continued From page 52</p> <p>additional information. The Administrator stated when you go into the medical record to document you have to click on a particular resident, and there was no alarm or anything to alert the staff member that they were typing into the wrong record. The Administrator stated she was not aware there were concerns with the AHT computer system.</p> <p>2. Review of Resident #6's clinical record revealed the facility admitted the resident on 07/01/12 with diagnosis of Hypertension, Hypothyroidism, Dementia with Behavior, Anxiety State, Iron Deficiency Anemia and Osteoporosis.</p> <p>Review of the Physician Orders for a Sensor Alarm to bed and wheelchair, dated 01/01/15, for Resident #6 revealed the sensor alarm was ordered related to increased fall risk.</p> <p>Review of Resident #6's Significant Change MDS assessment, completed on 02/11/15, revealed the facility assessed the resident utilizing the BIMS. The facility assessed the Resident #6's BIMS score as four (4) of fifteen (15), being severely impaired cognitively.</p> <p>Review of the AccuNurse (electronic documentation program), Activities of Daily Living (ADL) Plan of Care-Transfers for Resident #6, print dated 05/22/15, revealed monitoring of the alarms, included test and reapply bed or chair alarm; however, the facility did not provide documentation of any alarm monitoring.</p> <p>Observation on 05/19/15 at 1:40 PM and 2:09 PM, of Resident #6 revealed he/she was lying in the bed with the bed alarm attached to the bed.</p>	F 514	<p>system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>	



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F 514	<p>Continued From page 53</p> <p>He/she laid on his/her right side facing the window with the curtains closed.</p> <p>Observation on 05/20/15 at 7:40 AM, of Resident #6 revealed he/she was seated in the dining room for breakfast service. He/she was seated in his/her wheelchair at a table with an alarm attached to the back of the wheelchair.</p> <p>3. Review of Resident #9's clinical record revealed the facility re-admitted the resident on 04/04/14 with diagnosis of Depressive Disorder, Anxiety, Mental Disorder and Anemia.</p> <p>Review of Resident #9's Quarterly MDS assessment, completed on 02/16/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed the Resident #9's BIMS score as fourteen (14) of fifteen (15), being cognitively intact.</p> <p>Review of the Physician Orders for a Chair Alarm, dated 02/09/15, for Resident #9 revealed the chair alarm was to increase safety awareness. The facility was to check functioning and placement every shift.</p> <p>Review of the AccuNurse, Activities of Daily Living (ADL) Plan of Care-Transfers for Resident #9, print dated 05/22/15, revealed monitoring of the alarms, included test and reapply bed or chair alarm; however, the facility did not provide documentation of any alarm monitoring.</p> <p>Observation of Resident #9, on 05/19/15 at 11:48 AM, revealed he/she was seated in his/her wheelchair in the hallway near the resident's room. An alarm was attached to the back of his/her wheelchair.</p>	F 514		



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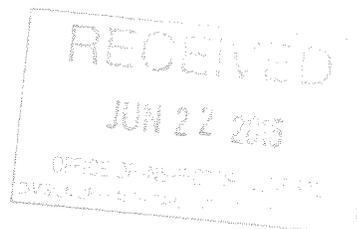
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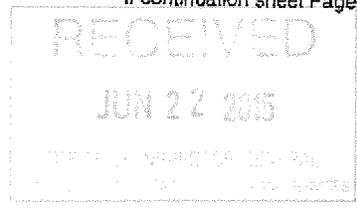
F 514	<p>Continued From page 54</p> <p>Observation of Resident #9, on 05/19/15 at 4:50 PM, revealed he/she was seated in his/her wheelchair. He/she was inside of Resident #1's door entrance engaged in conversation with Resident #1. An alarm was attached to the back of his/her wheelchair.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 05/22/15 at 10:15 AM, revealed everything about each resident was documented on the AccuNurse system. The alarms were listed on there also, but there were not any reminders when to check the alarms.</p> <p>Interview with Registered Nurse (RN) #2, on 05/22/15 at 10:15 AM, revealed everything about each resident was documented on the AccuNurse system. The alarms were listed on there also, not any reminders when to check the alarms.</p> <p>Interview with the Assistant Director of Nursing, on 05/22/15 at 10:40 AM, revealed the bed and chair alarms were checked every two hours on rounds by the CNAs. She stated the CNAs check the alarms every shift for functioning. She reported the bed and chair alarms were on the treatment administration record until about a one (1) year ago when the process was changed to the AccuNurse system as a CNAs task. She reported she was unable to provide the documentation the bed and chair alarms were checked.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 05/22/15 at 4:45 PM, revealed the facility was entering the bed and chair alarms under the transfers section on AccuNurse. She stated they were told today the system does not</p>	F 514		
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2015
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 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 514	<p>Continued From page 55</p> <p>document the testing of the alarms under the transfer section. She stated they were told today by AccuNurse Support the alarms had to be entered on the flow sheet under the ADL Plan of Care, in the bathing, dressing and positioning section for the system to capture the documentation. She stated they were entering the alarms under the devices section which did not document the testing and functioning of the alarms.</p> <p>The Director of Nursing was unavailable for interview. She was out of the country during the survey process.</p> <p>Interview with the Administrator, on 05/22/15 at 5:50 PM, revealed the she was not aware the computer system, AccuNurse, limited the input when the alarms were put under the devices section. She stated they previously had training, but had a lot of turnover. She stated she was not aware of the electronic documentation concerns until today.</p>	F 514			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2015
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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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 V (000)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet (anti-freeze) sprinkler system.</p> <p>GENERATOR: A new Type II, 80 KW generator was installed in April of 2014. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 05/20/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56).</p>	K 000	<p>Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The Provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p>	
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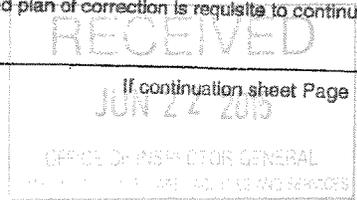
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

X Kirby S. Holden

TITLE
X Administrator

(X6) DATE
X 6/22/2015

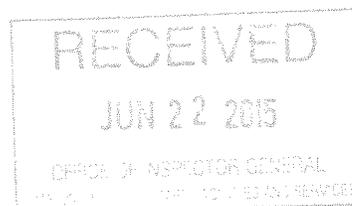
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
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K 000	Continued From page 1	K 000		
K 025 SS=F	<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 deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, sixty-five (65) residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56).</p>	K 025	<p>K025 Completion Date: 6/19/2015 SS=F NFPA 101 Life Safety Code Standard Attic Smoke Barrier Penetrations</p> <p>No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56.</p> <p>Contracted vendor (ABM Construction) fixed the smoke barrier on Lincoln Lane and Heritage Hall that required drywall installation. The concrete smoke barrier was also fixed by this vendor that was on Lincoln Lane and by the Therapy Room. The smoke barrier area in ceiling at Heritage Hall was also repaired by this vendor. The penetrations have been filled with a material rated equal to the partition and now can resist the passage of smoke. This work was completed by 6/11/2015.</p> <p>No other residents were identified as having the potential to be affected;</p>	



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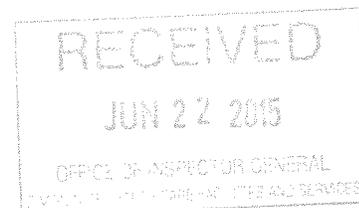
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2015
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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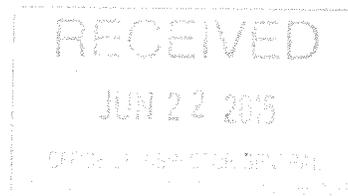
K 025	<p>Continued From page 2 The findings include:</p> <p>1.) Observation, on 05/20/15 at 9:22 AM, with the Maintenance Supervisor revealed exposed wood framing used to construct the smoke barrier located in the attic in the Lincoln Lane Hall by Room #18 was covered with gypsum board on only one (1) side.</p> <p>Interview, on 05/20/15 at 9:23 AM, with the Maintenance Supervisor revealed she was not aware of the requirements for the construction of smoke barriers.</p> <p>2.) Observation, on 05/20/15 at 9:32 AM, with the Maintenance Supervisor revealed unsealed penetrations around wires and an electrical chase located in the smoke barrier extending above the ceiling in the Heritage Hall.</p> <p>Interview, on 05/20/15 at 9:33 AM, with the Maintenance Supervisor revealed she was not aware of the penetrations in the smoke barrier.</p> <p>3.) Observation, on 05/20/15 at 9:38 AM, with the Maintenance Supervisor revealed exposed wood framing used to construct the smoke barrier located in the attic in the Heritage Hall was covered with gypsum board on only one (1) side.</p> <p>Interview, on 05/20/15 at 9:39 AM, with the Maintenance Supervisor revealed she was not aware of the requirements for the construction of smoke barriers.</p> <p>4.) Observation, on 05/20/15 at 9:50 AM, with the Maintenance Supervisor revealed an unsealed twelve (12) inch by twelve (12) inch penetration around electrical conduit located in the attic of the</p>	K 025	<p>however, day of inspection the census was at 56.</p> <p>Maintenance Supervisor checked all areas in the facility attic to ensure that no other areas needed repairs regarding smoke partition penetrations. There were no other areas identified. This was completed on 6/12/2015.</p> <p>The systemic changes implemented to prevent the reoccurrence of the deficient practice:</p> <p>Administrator re-educated and trained the Maintenance Supervisor on 5/27/2015 regarding the need to complete on-going inspections of the facility attic to check and repair smoke partition penetrations identified with routine checks. These inspections will be conducted monthly until the facility's next annual survey. This will be added to the monthly TELS System monthly monitoring.</p> <p>Monitoring for continued compliance will include the following:</p> <p>As stated above, the Maintenance Supervisor will do monthly inspections until the next annual survey, to the facility attic areas for smoke partition penetration issues and will repair, as appropriate. Documentation of inspections and action taken will be completed and maintained by</p>	
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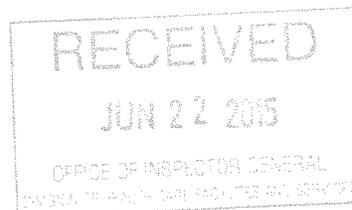
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2015
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K 025	<p>Continued From page 3</p> <p>smoke barrier in the Lincoln Lane Hall to the Therapy Hall.</p> <p>Interview, on 05/20/15 at 9:51 AM, with the Maintenance Supervisor revealed she was not aware of the penetration in the smoke barrier by the Therapy Hall.</p> <p>The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition) 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as</p>	K 025	<p>the Maintenance Supervisor by utilizing the TELS System.</p> <p>Administrator will report to the facility (PI) Quality Committee regarding the monthly inspections.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance until the next annual survey. The membership of this committee consist of at least the medical director, pharmacy consultation, director of nursing, assistant director of nursing, pharmacy consultant, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>	



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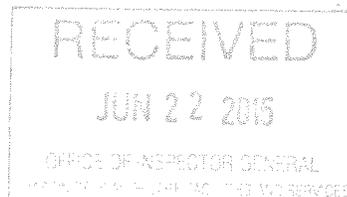
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K 025	Continued From page 4 follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a	K 027	K027 SS=F Completion Date: 6/19/2015	



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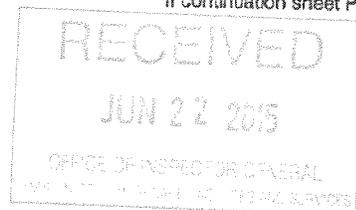
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K 027	<p>Continued From page 5</p> <p>20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, sixty-five (65) residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56).</p> <p>The findings include:</p> <p>1.) Observation, on 05/20/15 at 1:30 PM, with the Maintenance Supervisor revealed the cross-corridor doors located in the Lincoln Lane Hall would not close completely when tested. This was due to the coordinating device not being installed with all of the required components.</p> <p>Interview, on 05/20/15 at 1:31 PM, with the Maintenance Supervisor revealed she was not aware of how the coordinating device was intended to work.</p>	K 027	<p>NFPA 101 Life Safety Code Standard Fire Doors at both Nursing Stations and back of Lincoln Lane by Therapy Room</p> <p>No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56.</p> <p>Maintenance Supervisor ordered door sweeps to install on fire doors at the front of Heritage Hall and Lincoln Lane so they will close properly. Order placed 6/5/2015. Maintenance Supervisor installed these parts on 6/15/2015. These fire doors are now closing properly when doors are reentered.</p> <p>Maintenance Supervisor made adjustments to the fire doors at end of Lincoln Lane by Therapy Room on 6/5/2015. This fire door is now latching and working properly.</p> <p>No other residents were identified as having the potential to be affected; however, day of inspection the census was at 56.</p> <p>Maintenance Supervisor ordered door sweeps to install on fire doors at the front of Heritage Hall and Lincoln Lane so they will close properly. Order placed 6/5/2015. Maintenance Supervisor installed these parts on 6/15/2015. These fire doors are now closing properly when doors are reentered.</p> <p>Maintenance Supervisor made adjustments to the fire doors at end of Lincoln Lane by</p>	



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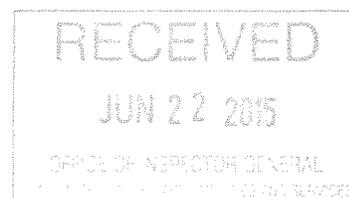
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K 027	Continued From page 6 2.) Observation, on 05/20/15 at 2:03 PM, with the Maintenance Supervisor revealed the cross-corridor doors located between Lincoln Lane and Rehab failed to close completely when tested. This was due to the self-closing device not being adjusted properly. Interview, on 05/20/15 at 2:04 PM, with the Maintenance Supervisor revealed she was not aware the doors were not closing properly. 3.) Observation, on 05/20/15 at 2:37 PM, with the Maintenance Supervisor revealed the cross-corridor doors located in the Heritage Hall would not close completely when tested. This was due to the coordinating device not being installed with all of the required components. Interview, on 05/20/15 at 2:38 PM, with the Maintenance Supervisor revealed she was not aware of how the coordinating device was intended to work. The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15. Actual NFPA Standard: Reference NFPA 101 (2000 Edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	Therapy Room on 6/5/2015 This fire door is now latching and working properly. The systemic changes implemented to prevent the reoccurrence of the deficient practice: Administrator provided education/training to the Maintenance Supervisor regarding the need to include checking the fire doors when fire drills are conducted monthly and to document findings and action taken in the TELS System going forward. This was completed by 6/2/2015. Administrator revised the Maintenance Supervisor's orientation training checklist to include this task. This was completed by 6/12/2015. Monitoring for continued compliance will include the following: Maintenance Supervisor does a fire drill monthly, and all fire doors will be checked for working properly. This will be a monthly task that will be completed and is part of documentation in the TELS System going forward. Administrator will report monthly findings to the facility (PI) Quality Committee for their oversight for on-going compliance. This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality	



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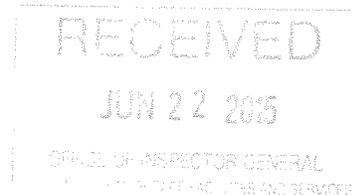
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K 027	Continued From page 7 Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors. Reference: NFPA 101 (2000 edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027	system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance until the next annual survey. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 045	K045 Completion Date: 6/19/2015 SS=D NFPA 101 Life Safety Code Standards Illumination of Means of Egress Lighting No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56.	



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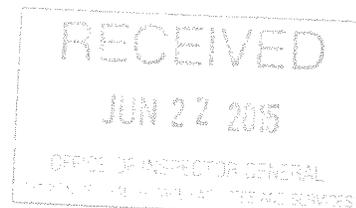
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2015
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K 045	<p>Continued From page 8</p> <p>determined the facility failed to ensure egress lighting was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56).</p> <p>The findings include:</p> <p>Observation, on 05/20/15 at 1:17 PM, with the Maintenance Supervisor revealed the sidewalk outside the Front Hall Exit by the Kitchen did not have illumination for the walking surface of the sidewalk as it rounded the old Staff Smoking Shed leading to the public way.</p> <p>Interview, on 05/20/15 at 1:18 PM, with the Maintenance Supervisor revealed she was not aware the sidewalk did not have illumination as required.</p> <p>The census of fifty-six (56) was verified by the Administrator on 05/20/15. The survey findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1*</p> <p>Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement,</p>	K 045	<p>Contracted Vendor (Hammer & Nails) installed a two bulb light fixture in the area between the kitchen side exit door egress area towards the front area of the facility. This was completed on 5/29/2015.</p> <p>No other residents were identified as having the potential to be affected; however, day of inspection the census was at 56.</p> <p>Contracted Vendor (Hammer & Nails) installed a two bulb light fixture in the area between the kitchen side exit door egress area towards the front area of the facility. This was completed on 5/29/2015.</p> <p>The systemic changes implemented to prevent the reoccurrence of the deficient practice:</p> <p>The Administrator requested that the task for the Maintenance Supervisor to check and inspect the functioning of lighting along outside egressed areas of the facility was added to the TELS System on 6/8/2015.</p> <p>Monitoring for continued compliance will include the following:</p> <p>Maintenance Supervisor will conduct monthly inspection of lighting along outside egressed areas of the facility, will address any issues identified, repair, and document in the TELS System. This inspection is to ensure that lighting outside egressed areas is</p>	



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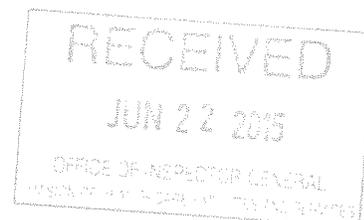
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K 045	Continued From page 9 exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that	K 045	working properly. This was effective for June 2015. Administrator will report to the facility (PI) Quality Committee regarding the outcome of these monthly inspections. This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for until the next annual survey. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	



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K 045	Continued From page 10 the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. 7.8.1.5 The equipment or units installed to meet the requirements of Section 7.10 also shall be permitted to serve the function of illumination of means of egress, provided that all requirements of Section 7.8 for such illumination are met. 7.8.2 Sources of Illumination. 7.8.2.1* Illumination of means of egress shall be from a source considered reliable by the authority having jurisdiction. 7.8.2.2 Battery-operated electric lights and other types of portable lamps or lanterns shall not be used for primary illumination of means of egress. Battery-operated electric lights shall be permitted to be used as an emergency source to the extent permitted under Section 7.9.	K 045		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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:	K 050	K050 Completion Date: 6/19/2015 SS=D NFPA 101 Life Safety Code Standards Kitchen Staff Not Knowing How to Extinguish a Fire in Kitchen No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56. Administrator developed education/training (continued on Page 11A)	



(continued from Page 11)

materials to teach and demonstrate how kitchen staff should address a fire in the kitchen. This was completed by 5/31/2015. Administrator conducted the education/training on how to deal with a fire in the kitchen to the Maintenance Supervisor and Dietary Manager. This was completed on 6/2/2015.

Dietary Manager conducted the education/training on how to deal with a fire in the kitchen to all dietary staff. This was completed by 6/8/2015.

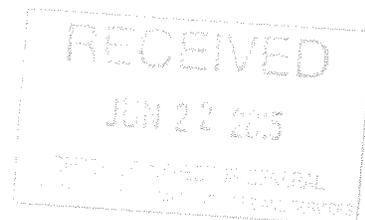
No other residents were identified as having the potential to be affected; however, day of inspection the census was at 56.

Administrator developed education/training materials to teach and demonstrate how kitchen staff should address a fire in the kitchen. This was completed by 5/31/2015.

Administrator conducted the education/training on how to deal with a fire in the kitchen to the Maintenance Supervisor and Dietary Manager. This was completed on 6/2/2015.

(continued on page 11B)

Page 11A



(Continued from page 11A)

Dietary Manager conducted the education/training on how to deal with a fire in the kitchen to all dietary staff. This was completed by 6/8/2015.

The systemic changes implemented to prevent the reoccurrence of the deficient practice:

Administrator updated the Dietary Departmental Orientation Checklist for all new dietary staff to receive training on how to deal with a fire in the kitchen. This was completed and effective on 6/8/2015. Administrator reviewed this with the Dietary Manager on 6/8/2015.

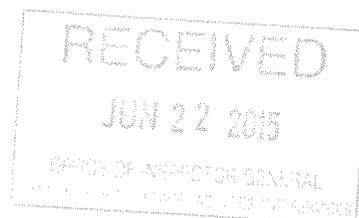
Monitoring for continued compliance will include the following:

Dietary Manager will question three dietary staff members monthly to assess their competency on the steps to take on how to deal with a fire in the kitchen. Results will be documented and reported to the (PI) Quality Committee. This will start for the month of June 2015.

Administrator will report monthly audit results to the facility (PI) Quality Committee.

(continued on page 12)

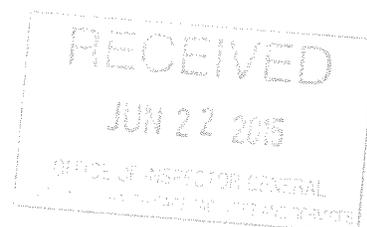
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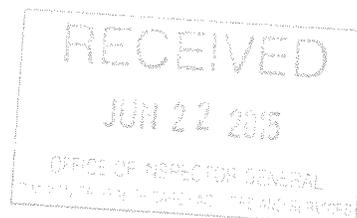
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2015
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K 050	Continued From page 11 Based on interview and record review, it was determined the facility failed to ensure staff was familiar with fire procedures in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56). The findings include: Interview, on 05/20/15 at 1:25 PM, with the Kitchen Staff revealed the Kitchen Staff did not know the proper procedures for a fire in the Kitchen. Interview, on 05/20/15 at 1:26 PM, with the Maintenance Supervisor revealed she was aware of the proper procedures for a fire located in the Kitchen. The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15. Actual NFPA Standard: Reference: NFPA 101 (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	(Continued from page 11) This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance until the next annual survey. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052	K052 SS=D NFPA 101 Life Safety Code Standards Completion Date: 6/19/2015	



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K 052	Continued From page 12 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56). The findings include: Observation, on 05/20/15 at 1:20 PM, with the Maintenance Supervisor revealed the manual fire pull located in the Kitchen was obstructed by a dish cart being stored in front of it. Interview, on 05/20/15 at 1:21 PM, with the Maintenance Supervisor revealed she was not	K 052	Fire Pull Station Blocked in Kitchen No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56. Administrator provided education/training to the Maintenance Supervisor and the Dietary Manager regarding the need to make sure that all fire pull stations and fire extinguishers are not blocked and are accessible at all times in the kitchen area. This was completed by 6/1/2015. Dietary Manager provided education/training to all dietary staff regarding the need to make sure that all fire pull stations and fire extinguishers are not blocked and are accessible at all times in the kitchen area. This was completed by 6/8/2015. No other residents were identified as having the potential to be affected; however, day of inspection the census was at 56. Administrator provided education/training to the Maintenance Supervisor and the Dietary Manager regarding the need to make sure that all fire pull stations and fire extinguishers are not blocked and are accessible at all times in the kitchen area. This was completed by 6/1/2015. (continued on page 13A)	



(continued from Page 13)

Dietary Manager provided education/training to all dietary staff regarding the need to make sure that all fire pull stations and fire extinguishers are not blocked and are accessible at all times in the kitchen area. This was completed by 6/8/2015.

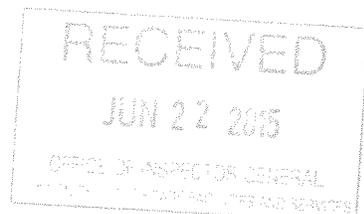
The systemic changes implemented to prevent the reoccurrence of the deficient practice:

The Administrator requested that the task for the Dietary Manager to monitor 5x weekly weeks, starting week of 6/8/2015 to ensure that fire pull stations in the kitchen area are not blocked and are accessible. This monitoring will be documented and Administrator will do reporting to the facility (PI) Quality Committee.

Monitoring for continued compliance will include the following:

Dietary Manager will conduct daily audits (five times weekly), starting week of 6/8/2015 to ensure that fire pull stations in the kitchen are not blocked and are accessible. Audits will be documented and any issues will be immediately addressed and documented. Administrator will ensure weekly audits are completed and will analyze the documentation. Administrator
(continued on Page 13B)

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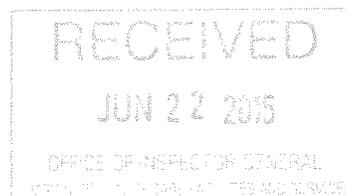


(continued from Page 13A)

will doing reporting to the facility (PI) Quality Committee.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance until the next annual survey. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality
(continued on Page 14)

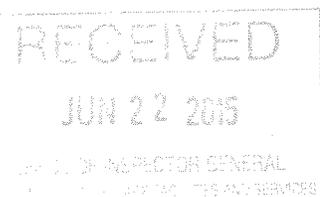
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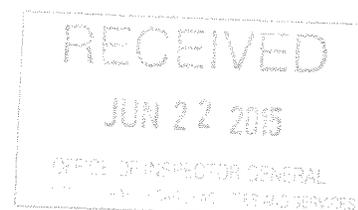
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K 052	Continued From page 13 aware the manual fire pull was obstructed by the dish cart. The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15. Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. NFPA 101 LIFE SAFETY CODE STANDARD	K 052	(continued from Page 13B) Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.		
K 062 SS=D	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the sprinklers were maintained, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice has the potential to affect one (1) of four (4) smoke compartments, thirty-two (32) residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems.	K 062	K062 Completion Date: 6/19/2015 SS=D NFPA 101 Life Safety Code Standard Dust on Sprinklers in Attic and Administration Storage Closet Two Boxes Stored Above 18 inches from Sprinkler Head No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56. Administrator directed the Maintenance Supervisor on 5/27/2015, to dust the insulation off the sprinklers in the attic of the facility. Maintenance Supervisor completed this task on 5/28/2015.		



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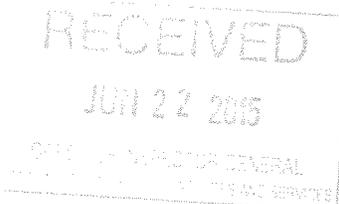
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K 062	Continued From page 14 The findings include: 1.) Observation, on 05/20/15 at 9:38 AM, with the Maintenance Supervisor revealed the sprinklers installed in the attic above the Heritage Hall were obstructed from developing a full spray pattern by dust and blow-in type insulation accumulating on the sprinkler heads. Interview, on 05/20/15 at 9:39 AM, with the Maintenance Supervisor revealed she was not aware the dust and insulation were accumulating on the sprinkler heads in the attic. 2.) Observation, on 05/20/15 at 2:34 PM, with the Maintenance Supervisor revealed storage within eighteen (18) inches of the sprinkler head located in the Administration Supply Closet in the Heritage Hall. Interview, on 05/20/15 at 2:35 PM, with the Maintenance Supervisor revealed she was not aware of the storage in the the Administration Supply Closet. The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15. Actual NFPA Standard: Reference: NFPA 13 (1999 Edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical	K 062	<p>specially address attic installed heads on 6/8/2015 for on-going monitoring.</p> <p>Administrator re-educated and trained the following employees, who have access to the administration storage closet: HR/Payroll Coordinator, Business Office Manager, and Maintenance Supervisor. The education and training stated that the ceiling clearance of 18 inches from sprinkler head must be abided by in this storage closet. No item is to be stored above the 18 inch line. This was completed on 5/27/2015.</p> <p>Monitoring for continued compliance will include the following:</p> <p>Administrator instructed the HR/Payroll Coordinator that monitoring was needed once weekly until the next annual survey, to ensure for on-going compliance with storing items below the 18 inch mark. This inspection was started for the week of 5/25/2015.</p> <p>Administrator will report to facility (PI) Quality Committee regarding the monthly inspections of the attic to ensure sprinklers are free from dust and any other materials or items.</p> <p>Administrator will report to facility (PI) Quality Committee regarding the weekly inspections of the administration storage closet to ensure no items are stored above the 18 inch mark with sprinkler heads.</p>	



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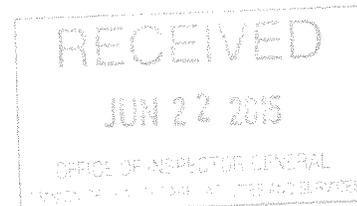
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2015																								
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K 062	Continued From page 15 damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP) <table border="1"> <thead> <tr> <th colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)</th> <th>of Deflector Obstruction (in.)</th> </tr> </thead> <tbody> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>21/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>31/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>51/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>71/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>91/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>161/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </tbody> </table> For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.)	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	of Deflector Obstruction (in.)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	21/2	1 ft 6 in. to less than 2 ft	31/2	2 ft to less than 2 ft 6 in.	51/2	2 ft 6 in. to less than 3 ft	71/2	3 ft to less than 3 ft 6 in.	91/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	161/2	5 ft and greater	18	K 062	Administrator directed the HR/Payroll Coordinator on 5/22/2015 to get the two boxes above the 18 inch point in the administration storage closet removed. This was completed on 5/22/2015. No other residents were identified as having the potential to be affected; however, day of inspection the census was at 56. Administrator directed the Maintenance Supervisor on 5/27/2015, to dust the insulation off the sprinklers in the attic of the facility. Maintenance Supervisor completed this task on 5/28/2015. Administrator directed the HR/Payroll Coordinator on 5/22/2015 to get the two boxes above the 18 inch point in the administration storage closet removed. This was completed on 5/22/2015. The systemic changes implemented to prevent the reoccurrence of the deficient practice: Administrator re-educated and trained the Maintenance Supervisor on 5/27/2015 regarding the need for on-going inspections of the facility attic to check to make sure that sprinklers in the attic are free from dust or any other materials or items. Any problems identified will be addressed and corrected. These inspections will be conducted monthly. The TELS System task instructions were updated corporate wide to	
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K 062	Continued From page 16 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062	This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance until the next annual survey. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, social service director, and the (continued on Page 17A)	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain fire extinguishers in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56). The findings include: Observation, on 05/20/15 at 1:20 PM, with the Maintenance Supervisor revealed the ABC Class	K 064	K064 Completion Date: 6/19/2015 SS=D NFPA 101 Life Safety Code Standard Fire Extinguishers Blocked in Kitchen Area No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56. Administrator provided education/training to the Maintenance Supervisor and the Dietary Manager regarding the need to make sure that all fire pull stations and fire extinguishers are not blocked and are accessible at all times in the kitchen area. This was completed by 6/1/2015.	



(continued from Page 17)

administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

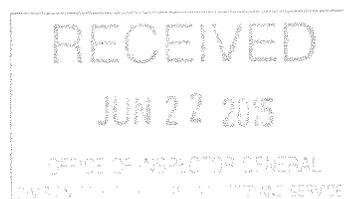
Page 17A



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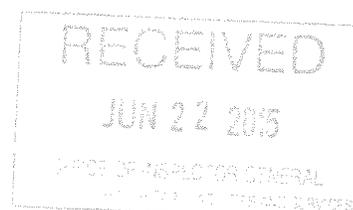
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K 064	<p>Continued From page 17</p> <p>fire extinguisher was not obstructed by a dish cart being stored in front of the extinguisher.</p> <p>Interview, on 05/20/15 at 1:21 PM, with the Maintenance Supervisor revealed she was not aware the extinguisher was obstructed.</p> <p>The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) 9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</p> <p>Reference: NFPA 10 (1998 edition)</p> <p>3-7 Fire Extinguisher Size and Placement for Class K Fires.</p> <p>3-7.1 Fire extinguishers shall be provided for hazards where there is a potential for fires involving combustible cooking media (vegetable or animal oils and fats).</p> <p>3-7.2 Maximum travel distance shall not exceed 30 ft (9.15 m) from the hazard to the extinguishers.</p>	K 064	<p>Dietary Manager provided education/training to all dietary staff regarding the need to make sure that all fire pull stations and fire extinguishers are not blocked and are accessible at all times in the kitchen area. This was completed by 6/8/2015.</p> <p>No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56.</p> <p>Administrator provided education/training to the Maintenance Supervisor and the Dietary Manager regarding the need to make sure that all fire pull stations and fire extinguishers are not blocked and are accessible at all times in the kitchen area. This was completed by 6/1/2015.</p> <p>Dietary Manager provided education/training to all dietary staff regarding the need to make sure that all fire pull stations and fire extinguishers are not blocked and are accessible at all times in the kitchen area. This was completed by 6/8/2015.</p> <p>The systemic changes implemented to prevent the reoccurrence of the deficient practice:</p> <p>The Administrator requested that the task for the Dietary Manager to monitor 5x weekly, starting week of 6/8/2015 to ensure that fire pull stations in the kitchen area are not</p>	



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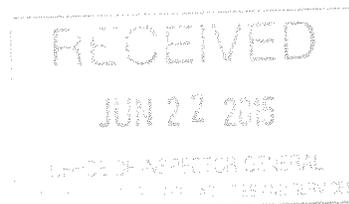
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K 064	Continued From page 18 Reference: NFPA 10 (1998 edition) 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d)* Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight	K 064	blocked and are accessible. This monitoring will be documented and Administrator will do reporting to the facility (PI) Quality Committee. Monitoring for continued compliance will include the following: Dietary Manager will conduct daily audits (five times weekly), starting week of 6/8/2015 to ensure that fire pull stations in the kitchen are not blocked and are accessible. Audits will be documented and any issues will be immediately addressed and documented. Administrator will ensure weekly audits are completed and will analyze the documentation. Administrator will do reporting to the facility (PI) Quality Committee. This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance until the next annual survey. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented	



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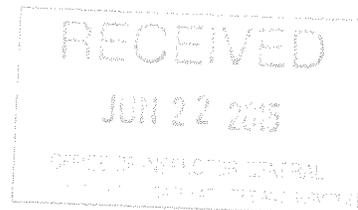
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K 064	Continued From page 19 not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficient practice has the potential to affect two (2) of four (4) smoke compartments, sixty-five (65) residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56). The findings include: 1.) Observation, on 05/20/15 at 9:14 AM, with the Maintenance Supervisor revealed the storage of two (2) three (3) compartment dirty linen/trash	K 072	K072 Completion Date: 6/19/2015 SS=E NFPA 101 Life Safety Code Standards Means of Egress Clear ---No Equipment Storage in Resident Hallways No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56. Administrator provided education and training to all administration management staff (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, LPN MDS Coordinator, Social Service Director, Business Office Manager, HR/Payroll Coordinator, Director of Admissions/Marketing, Dietary Manager, Activity Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor, and Supply/Medical Record Coordinator) regarding no equipment --- two three (3)	



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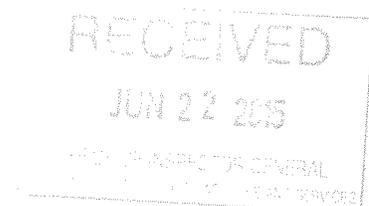
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K 072	Continued From page 20 carts in the egress path located in the Heritage Hall. Interview, on 05/20/15 at 9:15 AM, with the Maintenance Supervisor revealed the items were routinely stored in this location. 2.) Observation, on 05/20/15 at 9:58 AM, with the Maintenance Supervisor revealed the storage of two (2) three (3) compartment dirty linen/trash carts in the egress path located in the Lincoln Hall. Interview, on 05/20/15 at 9:59 AM, with the Maintenance Supervisor revealed the items were routinely stored in this location. The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Reference: NFPA 101 (200 Edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 31/2 in.	K 072	compartment dirty linen/trash carts are to be located in the resident halls --- Heritage Hall and Lincoln Lane. These carts can only be in resident hallways when nursing staff are changing bed linens and/or emptying trash from resident rooms. All other times the carts are to be stored off the resident hallways (i.e. shower rooms). This was completed by 6/5/2015. Administration Management Staff (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, Dietary Manager, and Housekeeping/Laundry Supervisor) who supervise staff then did education and training to their staff groups. This was completed by 6/12/2015. No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56. Administrator provided education and training to all administration management staff (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, LPN MDS Coordinator, Social Service Director, Business Office Manager, HR/Payroll Coordinator, Director of Admissions/Marketing, Dietary Manager, Activity Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor, and Supply/Medical Record Coordinator) regarding no equipment --- two three (3) compartment dirty linen/trash carts --- are to be located in the resident halls --- Heritage	



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K 072	Continued From page 21 (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.	K 072	(continued on Page 22A)	
K 144 SS=F	Reference: S&C-12-21-LSC NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-five (65) residents, staff and visitors. The facility has the capacity for sixty-five (65) beds with a census of fifty-six (56) on the day of the survey. The findings include: Observation, on 05/20/15 at 2:41 PM, with the Maintenance Supervisor revealed the battery charger located inside the generator enclosure to keep the battery charged for the emergency generator was connected directly to the battery terminals.	K 144	K144 Completion Date: 6/19/2015 SS=F NFPA 101 Life Safety Code Standards Generator No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56. Maintenance Supervisor contacted our facility vendor and scheduled for them to come to the facility to correct the issue with the generator battery charger. This was corrected on 6/8/2015 by rewiring the generator battery charger to the generator starter and engine lock then back to the battery charger instead of directly to the generator. No other residents were identified as having the potential to be affected; however, day of inspection the census was at 56. Maintenance Supervisor inspected the work that was completed by the facility vendor to ensure that the generator rewiring was completed as the invoice stated and communicated this to the Administrator. This was completed on 6/8/2015.	



(Continued from Page 22)

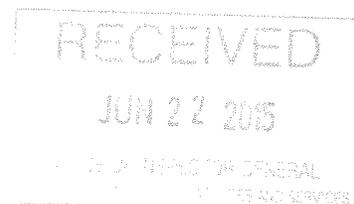
Hall and Lincoln Lane. These carts can only be in resident hallways when nursing staff are changing bed linens and/or emptying trash from resident rooms. All other times the carts are to be stored off the resident hallways (i.e. shower rooms). This was completed by 6/5/2015.

Administration Management Staff (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, Dietary Manager, and Housekeeping/Laundry Supervisor) who supervise staff then did education and training to their staff groups. This was completed by 6/12/2015.

The systemic changes implemented to prevent the reoccurrence of the deficient practice:

Administrator instructed the LPN Unit Manager and/or the Weekend RN unit Managers to monitor for compliance to ensure that no equipment is stored in the resident hallways --- Lincoln Lane or Heritage Hall. Monitoring will be completed at least 5x per week until the next annual survey. Monitoring documentation will include monitoring dates, times, findings, and any action taken when there are issues of noncompliance. Monitoring reports will be given to the Administrator (continued on Page 22B)

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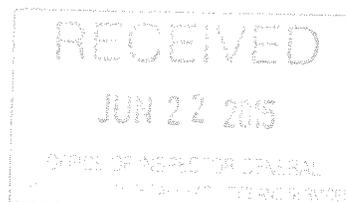
(continued from Page 22A)
for review. This monitoring will start for
the week of 6/8/2015.

**Monitoring for continued compliance will
include the following:**

Administrator will review the weekly
monitoring reports that are completed by
Unit Managers to analyze for any patterns or
trends and will do monthly reporting to the
facility's (PI) Quality Committee.

This plan of correction for monitoring
compliance will be integrated into the
facility's performance improvement quality
system where results will be reviewed and
monitored by the Performance Improvement
(PI) Quality Committee for ensuring on-
going compliance until the next annual
survey. The membership of this committee
consist of at least the medical director,
pharmacy consultant, director of nursing,
assistant director of nursing, business office
manager, social service director, and the
administrator. The committee meets at least
quarterly and more frequently as they deem
necessary when monitoring plans of
corrections. This PI Quality Committee will
review the effect of the implemented
changes and the audit findings, and if at any
time concerns are identified during this
monitoring process, the PI Quality
Committee will be convened to analyze and
recommend any further interventions, as
deemed appropriate.

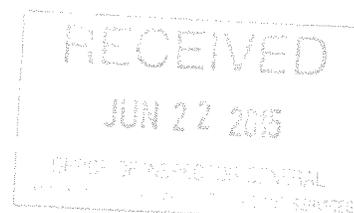
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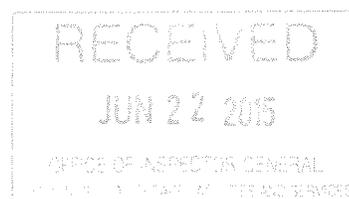
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2015
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 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 144	Continued From page 22 Interview, on 05/20/15 at 2:42 PM, with the Maintenance Supervisor revealed she was not aware the battery charger could not be connected directly to the battery terminals. The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15. Actual NFPA Standard: Reference: NFPA 110 (1999 Edition) 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144	The systemic changes implemented to prevent the reoccurrence of the deficient practice: Maintenance Supervisor conducts a weekly generator test that is monitored and documented in the TELS System. This test is to ensure that the generator starts automatically and shuts itself off automatically per timer settings. Monitoring for continued compliance will include the following: Maintenance Supervisor will submit documentation of the generator weekly testing to the Administrator that will be reviewed through the facility (PI) Quality Committee. (continued on Page 23A)	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to	K 147	K147 Completion Date: 6/19/2015 NFPA 101 Life Safety Code Standards Equipment (Hoyer Lifts and Treatment Carts) Parked in front of an Electrical Panel Resident Room Hallway	



(Continued from Page 23)

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance until the next annual survey. The membership of this committee consist of at least the medical director, Pharmacy consultant, director of nursing, assistant director of nursing, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

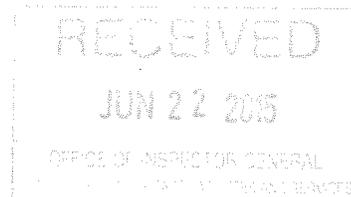
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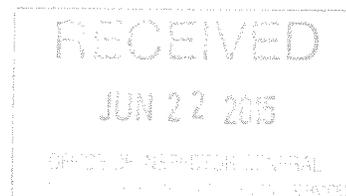
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2015
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K 147	<p>Continued From page 23</p> <p>affect one (1) of four (4) smoke compartments, thirty-two (32) residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was fifty-six (56).</p> <p>The findings include:</p> <p>Observations, on 05/20/15 at 2:30 PM, with the Maintenance Supervisor revealed the electrical panels located in the Heritage Hall Corridor were obstructed by a Hoyer Lift and Treatment Cart being stored in front of the electrical panels.</p> <p>Interview, on 05/20/15 at 2:31 PM, with the Maintenance Supervisor revealed she was unaware of the requirements for the spaces around electrical panels.</p> <p>The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 70 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less</p>	K 147	<p>No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 56.</p> <p>Administrator provided education and training to all administration management staff (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, LPN MDS Coordinator, Social Service Director, Business Office Manager, HR/Payroll Coordinator, Director of Admissions/Marketing, Dietary Manager, Activity Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor, and Supply/Medical Record Coordinator) regarding all electrical panels throughout the facility should never to block with a Hoyer Lift, Treatment Cart, or any other item or equipment. Hoyer Lifts and Treatment Carts are only to be on resident hallways when they are being used by nursing staff. Other times they are to be stored off resident hallways and not in any egress areas (i.e. shower rooms or other storage areas). This was completed by 6/5/2015.</p> <p>Administration Management Staff (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, Dietary Manager, and Housekeeping/Laundry Supervisor) who supervise staff then did education and training to their staff groups. This was completed by 6/12/2015.</p>		



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K 147	<p>Continued From page 24</p> <p>to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td>1 m (3½ ft)</td> <td></td> </tr> <tr> <td>1.2 m (4 ft)</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)		1.2 m (4 ft)				K 147	<p>No other residents were identified as having the potential to be affected; however, day of inspection the census was at 56.</p> <p>Administrator provided education and training to all administration management staff (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, LPN MDS Coordinator, Social Service Director, Business Office Manager, HR/Payroll Coordinator, Director of Admissions/Marketing, Dietary Manager, Activity Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor, and Supply/Medical Record Coordinator) regarding all electrical panels throughout the facility should never to block with a Hoyer Lift, Treatment Cart, or any other item or equipment. Hoyer Lifts and Treatment Carts are only to be on resident hallways when they are being used by nursing staff. Other times they are to be stored off resident hallways and not in any egress areas (i.e. shower rooms or other storage areas). This was completed by 6/5/2015.</p> <p>Administration Management Staff (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, Dietary Manager, and Housekeeping/Laundry Supervisor) who supervise staff then did education and training to their staff groups. This was completed by 6/12/2015.</p>	
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K 147	Continued From page 25 motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this	K 147	The systemic changes implemented to prevent the reoccurrence of the deficient practice: Administrator instructed the LPN Unit Manager and/or the Weekend RN unit Managers to monitor for compliance to ensure that Hoyer Lifts, Treatment Carts or any other item or equipment do not block any electrical panels in the facility. Monitoring will be completed at least 5x per week until the next annual survey. Monitoring documentation will include monitoring dates, times, findings, and any action taken when there are issues of noncompliance. Monitoring reports will be given to the Administrator for review. This monitoring will start for the week of 6/8/2015. Monitoring for continued compliance will include the following: Administrator will review the weekly monitoring reports that are completed by Unit Managers to analyze for any patterns or trends and will do reporting to the facility's (PI) Quality Committee. This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance until the next annual	

