

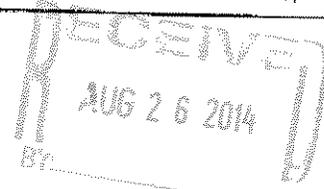
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

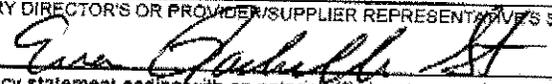
PRINTED: 08/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2014
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NAME OF PROVIDER OR SUPPLIER ELLIOTT NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A Standard Recertification Survey was conducted on 07/15/14 through 07/18/14. Deficient practice was identified with the highest scope and severity at an "E" level.	F 000		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		Elliott Nursing & Rehabilitation Center endeavors to post nurse staffing information on a daily basis in a prominent place readily accessible to residents and visitors. On 7/18/2014 the Administrator moved the daily staffing sheet from the bulletin board behind the nurse's station to a clear sign holder that was placed on the nurse's station to ensure visual accessibility to residents and visitors. On 7/29/2014 The Social Services Director interviewed all alert and oriented residents and found that no resident was effected by the previous nurse staffing posting location. Also on 7/29/2014 during Resident Council the Activities Director explained to the members what the nurse staffing report is and where the nurse staffing report is posted. On 7/23/2014 the Administrator provided additional education to all licensed nursing staff regarding the requirements for daily posting of nurse staffing information. This education included the change in location of the daily nurse staffing information. The DON/RN Supervisor will conduct weekly audits to ensure that the staffing sheet is posted in the designated area. Audits will be conducted at least 3 times per week for 4 weeks and weekly thereafter. Any infraction will be corrected immediately and education will be provided to the charge nurse at time of incident. The results of these audits will be forwarded to the monthly QAPI committee meeting for further review and continued compliance. Administrator

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/26/2014
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 356	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to post the facility's staffing information in a prominent place that was readily accessible to residents, families and visitors. Observation during the survey revealed staffing information was posted on a small bulletin board behind the nurses station in a hallway leading to the medication room. The findings include: Review of the facility's policy, titled "Daily Nurse Staffing Information" (dated 08/01/12), revealed the facility's daily staffing information should include the name of the facility, current posting date, resident census and Full Time Equivalent (FTE, a unit indicating the workload of an employed person) for Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides. Further review revealed the posted information was to be updated as needed for staffing changes occurring throughout the twenty-four (24) hour period. Continued review revealed the staff information should be posted in a public area that was accessible to residents and visitors. Observation, on 07/15/14, 07/16/14, 07/17/14 and 07/18/14, revealed the facility's staffing information was posted on an eight and one-half inch by eleven inch sheet of paper on a bulletin board located behind the main nurses station (a non-public area) in a short hallway leading to the medication room. Further observation revealed	F 356		
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F 356	Continued From page 2 the paper was visible from the public area around the nurses station; however, the information was not legible and accessible to residents and visitors outside the nurses station, contrary to the facility's policy. Interview with the Director of Nursing (DON), on 07/18/14 at 6:00 PM, revealed the area behind the nurses station was a non-public area. Further interview revealed the staffing information should be posted in a public area for all residents, families and visitors to have access to. The DON stated the posting of staffing information was important, in order for residents and families to know "who's taking care of their family". Interview with the Administrator, on 07/18/14 at 1:02 PM, revealed it was the facility's policy to post staffing information for family, residents and visitors to view. Further interview revealed the information was posted behind the main nurses station on a bulletin board. The Administrator stated if a resident, family or visitor could not see the information, they could ask staff and the facility would provide the information. Interview with the Regional Director of Clinical Operations, on 07/18/14 at 7:00 PM, revealed the facility should post staffing information in a public place. Further interview revealed she felt the information posted behind the nurses station was accessible to residents, families and visitors.	F 356			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	Elliott Nursing & Rehabilitation Center (ENRC) endeavors to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	08/15/2014	

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F 441 Continued From page 3
to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policies, it was determined the facility failed to ensure infection control practices were

F 441

On 7/18/2014 The RN Supervisor immediate cleaned all of the blood glucose testing meters per the manufacturer recommendations for the Micro-Kill Bleach Germicidal Bleach Wipes.

On 7/18/2014 The Administrator re-educated the DON regarding the appropriate use of disinfectant, and cleansing technique based on the manufacturer recommendations for the blood glucose testing meter, including compliance with the recommended contact (wet time).

On 7/16/2014 the RN Supervisor re-educated CMA#6, LPN # 2 and on 7/17/2014 CMT #7 regarding proper glove use and proper hand washing techniques per the Infection Control policies.

On 7/18/2014 the RN Supervisor re-educated SRNA #6 regarding proper cleaning and storage of bed pans urinals and toothbrushes per Infection Control policies.

On 7/16/2014 the RN Supervisor re-educated SRNA #1 regarding hand hygiene while handling residents' food per Infection Control policies. The Infection Control Log was reviewed by the DON on 7/23/2014. A look back period of six months indicated that no resident had been adversely affected by this deficient practice. Staff education began on 7/18/2014 and will be completed by 8/14/2014. All licensed nursing staff will be re-educated to follow recommended manufacturer recommendations for disinfection of blood glucose testing meter after each use. Education content will include the appropriate use of disinfectant, and cleansing technique based on the manufacturer recommendations, including compliance with the recommended contact (wet time). Staff competencies for cleaning and disinfection of the blood glucose meter will be updated and completed based on the manufacturer recommendations for disinfection no later than 8/14/2014. Licensed nursing staff have been provided with a timer that is being

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F 441 Continued From page 4
maintained related to disinfection of blood glucose monitoring equipment, hand hygiene during medication pass and meal service, and storage of urinals, bedpans and toothbrushes.

The findings include:

1) Review of the facility's policy for the facility-specific glucose meter, titled "Maintenance; Cleaning and Disinfecting;" (undated), revealed staff were to clean and disinfect the blood glucose meters between each resident use to avoid cross-contamination. Further review revealed when utilizing a commercially available disinfectant detergent or germicide wipe, staff were to follow the product label instructions to disinfect the meter.

Review of the product label instructions for the facility's disinfectant wipes, Micro-Kill Bleach Germicidal Bleach Wipes, revealed seven (7) of the ten (10) listed organisms required a five (5) minute contact time. Continued review revealed the contact time was the amount of time a surface must remain wet with the germicidal product to achieve disinfection.

Observation during a glucose monitoring procedure, on 07/16/14 at 1:39 PM, revealed staff utilized a glucose monitoring machine for a resident, wiped the machine with a Micro-Kill Bleach Germicidal Bleach Wipe, and placed the monitor in the medication cart drawer without timing the contact time with the germicidal product.

Interview with Licensed Practical Nurse (LPN) #5, on 07/18/14 at 11:30 AM, revealed she was responsible for performing blood glucose

F 441 utilized with each disinfection of the glucometer to ensure wet time adherence is observed.

All nursing staff will be reeducated by the DON/RN Supervisor by 8/14/2014 regarding the importance of maintaining an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development of transmission of disease and infection. This reeducation will include a review of proper infection control techniques and review of information obtained on the CDC website. The education will emphasize proper hand washing, proper storage, and labeling of bedpans, urinals, suction machine canisters and toothbrushes, and proper hand hygiene while handling resident's food.

The DON/RN Supervisor will visually monitor via daily compliance rounds (on all shifts) various aspects of the infection control program at least 3 times per week for 4 weeks and once a month ongoing. Any infraction will be addressed

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F 441 Continued From page 5
 monitoring. Further interview revealed she did not time how long the machine stayed wet after wiping it down, and was not aware disinfection of the machine required a contact time of five (5) minutes.

Interview with the Director of Nursing (DON), on 07/18/14 at 5:12 PM, revealed she also served as the Infection Control Nurse. She stated she was aware the "kill time" was five (5) minutes, but was not aware the machine needed to stay wet for five (5) minutes to in order to kill the organisms. Further interview revealed the machines should be disinfected per the product label directions in order to decrease the risk of cross-contamination. The DON further stated she planned to research other disinfectant products to potentially achieve disinfection of the machines in a more timely manner. Continued interview revealed she had not identified an increase in infections related to inappropriate disinfection practices.

Interview with the Administrator, on 07/18/14 at 5:46 PM, revealed staff should be disinfecting the glucose monitoring machines per the product directions due to infection control concerns.

2) Review of the facility's policy titled "Handwashing and Hand Hygiene - All Staff", dated 12/01/10, revealed handwashing or the use of alcohol rubs was recognized as the most basic and most effective means of preventing and controlling the spread of infection. Further review revealed the purpose of hand hygiene was to remove contaminants acquired by contact with infected residents or environmental sources. Continued review of the policy revealed staff were to perform hand hygiene before and after contact with a resident, before and after performing

F 441 immediately with one-on-one education. The DON/RN Supervisor will audit 1 blood glucose procedure per shift for the next 4 weeks. After the 4 week period, 1 procedure will be monitored per month thereafter. This shall continue monthly until a 100% compliance rate is achieved for three consecutive months. Any violation will be addressed with one-on-one education. In addition, the DON/RN Supervisor will complete 5 observations of hand washing per week. This will be random and will include all shifts. Any violation will be addressed with one-on-one education. The results of the daily compliance rounds and the observations will be forwarded to the monthly Quality Improvement committee meeting for further review and continued compliance.

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F 441 Continued From page 6

invasive procedures such as administering injections, or performing catheterizations or suctioning, and before preparing medications and as appropriate throughout medication distribution.

Review of the facility's policy, titled "Enteral Tube Medications Administration" (undated), revealed staff should wash their hands and apply gloves before administering medications via an enteral tube (a tube placed directly into the intestine through the skin and abdominal wall).

Observation during a medication pass, on 07/16/14 at 10:23 AM, revealed Certified Medication Aide (CMA) #6 had just completed a medication administration. While in the resident's room CMA #6 obtained paper towels, placed the paper towels on the resident's soiled sink counter, turned the faucet on with her soiled hands, washed her hands, turned the soiled faucet off with her clean hands, then proceeded to pick up the paper towels from the sink counter and dried her hands.

Interview with CMA #6, on 07/16/14 at 5:56 PM, revealed she should not have turned the soiled faucet off with her clean hands and should not have used the paper towel from the resident's sink counter. Further interview revealed she contaminated her clean hands when she touched the faucet and picked up the paper towels from the sink counter. She stated it was cross-contamination and was an infection control issue.

Observation of an enteral medication administration, on 07/16/14 at 2:10 PM, revealed Licensed Practical Nurse (LPN) #2 pushed the medication cart to a resident room, obtained the

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F 441	Continued From page 7 medication, crushed the medication, went into the resident's room, obtained gloves and proceeded to administer the medication via the enteral tube without washing or sanitizing hands prior to preparing the medication or administering the medication. Interview with LPN #2, on 07/16/14 at 2:26 PM, revealed she did not wash her hands prior to preparing or administering the medications. Further interview revealed she should have washed or sanitized her hands to decrease the risk for cross-contamination. LPN #2 stated she was "nervous". Observation during a medication pass, on 07/17/14 at 11:30 AM, revealed Certified Medication Technician (CMT) #7 washed her hands and donned gloves, contaminated her gloves when she removed eye medication from a uniform pocket, and proceeded to administer the eye medication with the contaminated gloves. Interview with CMT #7, on 07/17/14 at 11:36 AM, revealed she should not have taken the medication out of her uniform pocket after washing her hands and donning her gloves. Further interview revealed she contaminated her clean gloved hands with the soiled uniform and contents of her pocket. Interview with the DON/Infection Control Nurse, on 07/18/14 at 4:52 PM, revealed staff should wash or sanitize their hands prior to preparing a resident's medication, and prior to and after administering the medication by any route, in order to maintain infection control and reduce the risk of cross-contamination. In addition, she stated when the paper towel was retrieved with	F 441			

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F 441	<p>Continued From page 8</p> <p>soiled hands and laid on the sink counter, it was considered contaminated; staff should not have touched the paper towel with soiled hands, then used the contaminated paper towel to dry her clean hands. Continued interview revealed after washing their hands, staff should use a paper towel to turn the faucet off. The DON further stated staff should wash or sanitize their hands after touching their uniform clothing and prior to providing resident care.</p> <p>Interview with the Administrator, on 07/18/14 at 5:46 PM, revealed her expectation was for staff to wash their hands prior to and after any resident care or medication administration. Continued interview revealed failure to adhere to proper hand washing was an infection control issue. The Administrator stated staff should follow the facility's infection control policies to decrease cross-contamination.</p> <p>3) Review of the facility's policy titled "Cleaning and Disinfecting Non-critical Resident-Care Items" (revised August 2009), revealed bedpans and urinals were for use by only one resident (single resident use), and should be cleaned and disinfected between uses by a single resident. Further review revealed single resident use items should be marked with the resident's name and/or room number.</p> <p>Observation during the initial tour, on 07/15/14 at 2:05 PM, revealed the following: the shared resident bathroom for Room 104 contained a bedpan and a urine graduate container which was not labeled with a resident name or room number; the shared bathroom for Room 105 held a urinal and a graduate container with no resident name or room number; the shared bathroom for</p>	F 441	

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F 441	<p>Continued From page 9</p> <p>Room 108 was noted to have two (2) suction canisters with no resident name or room number; and the shared bathroom for room 212 was observed to have an unlabeled toothbrush lying on the sink counter under the soap dispenser and near the paper towel dispenser.</p> <p>Interview with State Registered Nurse Aide (SRNA) #6, on 07/16/14 at 5:56 PM, revealed the suction canisters, bedpans and urinals should be stored in the resident's night stand or in a bag in the bathroom with the resident's name on each item to ensure that item was used only for that resident. Further interview revealed toothbrushes should be labeled with the resident's name and stored in the resident's closet or night stand drawer.</p> <p>Further interview with the DON/Infection Control Nurse, on 07/18/14 at 4:52 PM, revealed the bedpans, urinals and suction canisters should be labeled with the resident's name due to the bathrooms being shared by two (2) semi-private rooms. Further interview revealed toothbrushes and denture cups should be labeled with the resident's name, covered and stored in the residents closet or bedside drawer to decrease the risk of cross-contamination.</p> <p>Further interview with the Administrator, on 07/18/14 at 5:46 PM, revealed the bedpans, urinals, suction canisters, and toothbrushes should be labeled with the resident's name on the item. Additionally, toothbrushes should be stored in the resident's night stand drawer, not on the sink counter due to infections control issues. Continued interview revealed the bedpans, urinals and suction canisters should be stored in the bathroom, and labeled with the resident's</p>	F 441		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 10 name.</p> <p>4) Interview with the Administrator, on 07/16/14 at 3:57 PM, revealed the facility did not have a policy which addressed hand hygiene while handling residents' food.</p> <p>Observation, on 07/16/14 at 10:00 AM, revealed State Registered Nursing Assistant (SRNA) #1 touched a resident's toast with an ungloved hand when she buttered one slice, then a second slice. Continued observation revealed SRNA #1 proceeded to push the toast onto the plate with the palm of her bare hand.</p> <p>Interview with SRNA #1, on 07/16/14 at 2:10 PM, revealed she did not realize she had buttered the resident's toast without a glove on. She stated she should have worn a glove when she touched the bread. Continued interview revealed she should not handle food without a glove in order to keep from spreading germs. She further stated she was in a hurry and was nervous at the time the observation was made.</p> <p>Interview with the DON/Infection Control Nurse, on 07/18/14 at 4:52 PM, revealed staff should not touch a resident's food with their bare hands due to potential cross-contamination. She stated it was an infection control concern.</p> <p>Interview with the Administrator, on 07/18/14 at 5:46 PM, revealed staff should not touch a resident's food with their bare hands due to infection control and the risk for cross-contamination.</p>	F 441		

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

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NAME OF PROVIDER OR SUPPLIER ELLIOTT NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

Building: 01

Survey under: NFPA 101 (2000 Edition)

Plan approval: 1995

Facility type: SNF/NF

Type of structure: One story, Type V (000)

Smoke Compartment: Three (3)

Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, heat detectors in HVAC of Light House Unit.
Upgraded panel in 2009

Sprinkler System: Complete sprinkler system (DRY).

Generator: Type 2 generator powered by diesel

A standard Life Safety Code survey was conducted on 07/15/14. Elliot Nursing and Rehabilitation Center was found to be 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 census on the day of the survey was seventy (70). The facility is licensed for seventy five (75) beds.

K 000 The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the following action.

RECEIVED
AUG 26 2014

K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

K 000

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

[Signature]

TITLE
Administrator

(X6) DATE
8/28/2014

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 ELLIOTT NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171
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K 000	<p>Continued From page 1 Building: 02</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 2009</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story , Type V (000)</p> <p>Smoke Compartment: Three (3)</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, heat detectors in HVAC of Light House Unit. Upgraded panel in 2009</p> <p>Sprinkler System: Complete sprinkler system (DRY).</p> <p>Generator: Type 2 generator powered by diesel</p> <p>A standard Life Safety Code survey was conducted on 07/15/14. Elliot Nursing and Rehabilitation Center (Light House Unit) was found to not be 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 census on the day of the survey was seventy (70). The facility is licensed for seventy five (75) beds.</p> <p>Deficiencies were cited with the highest deficiency identified at D Level.</p>	K 000		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 072	It is the policy of Elliott Nursing & Rehabilitation Center (ENRC) to ensure that all means of egress are continuously maintained free of all obstructions	08/15/2014

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K 072 Continued From page 2

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 ensure corridors were maintained free from obstructions, for full instant use in the case of fire or other emergency, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, fifteen (15) residents of seventy five (75) residents, staff and visitors.
The findings included:
Observation, on 07/15/2014 at 3:15 PM, revealed the exit corridors were obstructed by a piano, couch, chair and table. The items restricted the overall exit corridor width from eight (8) ft to five (5) ft. The items were not secured to the floor or wall. Further observation revealed chairs and tables were located at the end of each corridor in the Light House Unit. The findings were confirmed with the Maintenance Director. Interview with the Maintenance Director revealed he was not aware the items could not be in the corridors.

The findings were acknowledged with the Administrator during exit conference.

Reference: NFPA 101 (2000 edition)
7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or

K 072

or impediments to full instant use in the case of fire or other emergency.

On 7/15/2014 the Maintenance Director removed the piano, couch, and all chairs and tables from the exit corridor.

On 7/21/2014 the Regional Maintenance Director educated the facility Maintenance Director regarding the importance of ensuring that all means of egress are continuously maintained free of all obstructions or impediments.

An environmental audit was conducted by the Regional Maintenance Director and the Maintenance Director on 7/21/2014 to identify any areas of further concern regarding means of egress. All identified issues have been addressed.

The Maintenance Director will audit all means of egress monthly to ensure that all means of egress are continuously maintained free of all obstructions or impediments.

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K 072	Continued From page 3 impediments to full instant use in the case of fire or other emergency. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof. Survey and Certification from Centers For Medicare/Medicaid 12-21-LSC	K 072	The Administrator will audit a sample of means of egress monthly to ensure that all means of egress are continuously maintained free of all obstructions or impediments. The results of these audits will be forwarded to the monthly QAPI committee for further review and continued compliance.	