

08/20/2013 12:22 16067389410

A

PAGE 04/05

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

PRINTED: 08/09/2013
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 C 07/26/2013
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		
(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 000	INITIAL COMMENTS A Standard Recertification Survey was conducted 07/23/13 through 07/26/13. Deficiencies were cited with the highest scope and severity of an "E". In addition, an Abbreviated Survey to Investigate #KY00020455 was conducted 07/23/13 through 07/26/13. The allegation was unsubstantiated with an unrelated deficiency cited as a "D".	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(e). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	It is the policy of Elliott Nursing & Rehabilitation Center to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a need to alter treatment significantly. Resident #14 was discharged from the facility prior to survey and is not expected to return. The DON, RN Supervisor and the LPN Charge nurse will review all resident records for the last 60 days by 8/23/13 to ensure that any changes in resident status have been communicated to the family and recorded in the nursing notes. Any noted changes found not to be communicated will be shared with the family and a follow up note will be recorded in the resident's medical record. The DON and RN Supervisor completed re-education for all nursing staff on 8/15/13 regarding the facility policy related to timely notification of resident's legal representative or an interested family member when a significant change in condition or change in physician's order occurs. This education included the requirement that documentation must be recorded in the resident record when notification occurs.	09/06/2013	
ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rachelle St...</i>			TITLE Administrator		(X6) DATE 8/16/13

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 team participation.

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO 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 000 INITIAL COMMENTS

A Standard Recertification Survey was conducted 07/23/13 through 07/26/13. Deficiencies were cited with the highest scope and severity of an "E". In addition, an Abbreviated Survey to investigate #KY00020455 was conducted 07/23/13 through 07/26/13. The allegation was unsubstantiated with an unrelated deficiency cited at a "D".



F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=D (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

F 000

F 157 09/06/2013

It is the policy of Elliott Nursing & Rehabilitation Center to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a need to alter treatment significantly. Resident #14 was discharged from the facility prior to survey and is not expected to return. The DON, RN Supervisor and the LPN Charge nurse will review all resident records for the last 60 days by 8/23/13 to ensure that any changes in resident status have been communicated to the family and recorded in the nursing notes. Any noted changes found not to be communicated will be shared with the family and a follow up note will be recorded in the resident's medical record. The DON and RN Supervisor completed re-education for all nursing staff on 8/15/13 regarding the facility policy related to timely notification of resident's legal representative or an interested family member when a significant change in condition or change in physician's order occurs. This education included the requirement that documentation must be recorded in the resident record when notification occurs.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

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

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

PRINTED: 08/09/2013
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 C 07/26/2013
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	
(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 157; Continued From page 1

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of the facility's policy, it was determined the facility failed to immediately inform the resident's responsible party when there was a change in the resident's physical, mental, or psychosocial status that involved an alteration in treatment for one (1) of fifteen (15) sampled residents (Resident #14). The facility failed to inform Resident #14's responsible party of the resident's change in status after excoriation was noted to his/her perineal area. In addition, Resident #14's responsible party was not notified of changes in treatments related to excoriated areas.

The findings include:

Review of the facility's policy titled "Notification of Changes", effective 05/30/13, revealed the purpose of the policy was to ensure family members/responsible parties of residents were informed of changes in the resident's medical condition and/or treatment. The policy stated the licensed nurse would notify the resident's legal representative or family member when changes in condition and/or treatments occurred.

Review of the clinical record revealed the facility re-admitted Resident #14, on 07/04/13, with diagnosis which included Chronic Respiratory Failure, Congestive Heart Failure, Diabetes

F 157:

The DON or RN supervisor will audit via daily nursing meeting (Monday- Friday) by reviewing the physician's orders, pertinent nursing notes and nursing report sheets to ensure that documentation regarding notification has occurred per facility policy. Audits will be conducted at least 3 times per week for 4 weeks to identify any areas for improvement and at least weekly thereafter. The results of these audits will be forwarded to the monthly CQI committee meeting for further review and continued compliance.

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(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 157 Continued From page 2
Melitis Type II, Chronic Kidney Disease, Anemia, Hypertension, Chronic Ischemic Heart Disease, Morbid Obesity and Esophageal Reflux.

Review of Resident #14's Physician's Orders revealed an order, dated 07/10/13, for Silvadene cream to be applied to his/her groin three times daily (TID) related to excoriation. Continued review of the Physician's Orders revealed an order, dated 07/13/13, for Resident #14 to have the Silvadene cream discontinued and Nystatin cream to be applied to his/her groin, sacral and perineal areas TID related to a rash. Diflucan (a medication used to treat fungal/yeast infections) 100 mg by mouth daily had been ordered for Resident #14, on 07/13/13, due to a yeast infection. Resident #14's Physician's orders for, 07/10/13 and 07/13/13, were noted by LPN #3.

Review of Resident #14's Nurse's Notes revealed there was no documented evidence, Resident #14's family was notified of the excoriation/yeast to his/her sacral, groin or peri areas. There was also no documented evidence Resident #14's responsible party was notified of the treatments and changes in treatments ordered, on 07/10/13 and 07/13/13.

Interview with Resident #14's responsible party, on 07/25/13 at 4:00 PM, revealed the facility did not notify him of the excoriation/yeast to his/her sacral, groin and peri areas. Resident #14's responsible party was also unaware of any treatments ordered for excoriation or yeast to Resident #14's sacral, groin and peri areas.

Interview with Licensed Practical Nurse (LPN) #2, on 07/24/13 at 3:24 PM, revealed nurses were to contact the resident's family/responsible party

F 157

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157 Continued From page 3
when changes in orders or conditions occurred. LPN #2 stated these notifications should be recorded in the nurse's notes.

F 157

Interview with LPN #3, on 07/24/13 at 3:26 PM, revealed nurses were to document notification of the resident's responsible party in the nurses notes when a change in skin condition or Physician's orders occurred. LPN #3 stated Resident #14 had excoriated areas to his/her sacral and groin areas which were being treated at the facility.

Continued interview with LPN #3, on 07/26/13 at 10:43 AM, revealed she was not sure if she had notified Resident #14's responsible party when new orders were received, on 07/10/13, for Silvadene cream to be applied related to excoriation of Resident #14's groin. Furthermore, LPN #3 stated she was not sure if she had notified Resident #14's responsible party of the new orders received, on 07/13/13, for Nystatin Cream and Diflucan due to a rash/yeast infection of his/her sacral, groin, and peri areas. After reviewing the resident's medical record, LPN #3 stated she could find no documented evidence of family notifications related to the treatment or assessment of Resident #14's excoriation/yeast to his/her sacral, groin, and peri areas. LPN #3 stated it was important to notify the resident's responsible party of changes, so they would be aware of the resident's condition.

Interview with the Acting Director Of Nursing (DON), on 07/26/13 at 9:22 AM, revealed Resident #14's responsible party should have been notified of changes in his/her skin condition as well as the treatments as they were ordered. The Acting DON stated nurses were expected to

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO 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 157 Continued From page 4
document the notification of family members in the resident's nurses notes.

F 157

Interview with the Administrator, on 07/26/13 at 4:50 PM, revealed staff should have notified Resident #14's family of the the excoriation/yeast to his/her peri area. The Administrator stated she also expected staff to notify family any time a new order was received as per the facility's policy.

F 278 483.20(g) - (j) ASSESSMENT
SS=D ACCURACY/COORDINATION/CERTIFIED

F 278 It is the policy of Elliott Nursing & Rehabilitation Center 09/06/2013

The assessment must accurately reflect the resident's status.

that assessments must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

Resident #1's Minimum Data Set was corrected by MDS Coordinator on 07/26/2013 to include the fall that occurred in the look back period prior to transmission to CMS.

A registered nurse must sign and certify that the assessment is completed.

On 7/29/13 The MDS nurse was re-educated by the Administrator regarding the importance of correctly coding all Minimum Data Sets based on assessments that accurately reflect the resident's status. On 8/15/13 the Administrator provided education to additional members of the IDCPT regarding accurate coding on the MDS.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

The IDCPT will review the last assessment for each resident by 8/22/13 to ensure that they are coded correctly and accurately reflect the resident's status. Any necessary corrections will be made and an accurate MDS will be re-submitted if necessary.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO 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 278 Continued From page 5
material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the initial Minimum Data Set (MDS) assessment accurately reflected the resident's status for one (1) of fifteen (15) sampled residents. Resident #1 sustained a fall, on 07/14/13 which was not indicated on his/her MDS assessment.

The findings include:

Review of the facility's policy titled, "MDS-RAI", effective 08/01/12, revealed a comprehensive assessment of each resident's needs would be completed. The policy prompted staff to refer to the RAI (Resident Assessment Instrument) Manual for guidance.

Review of the RAI Manual Version 3.0, dated April 2012, revealed a fall was defined as any unintentional change in position coming to rest on the ground, floor or onto the next lower surface. The manual stated for an initial/admission assessment, the resident's medical record was to be reviewed from the time of admission to the ARD (Assessment Reference Date). The manual instructed staff to code a zero (0) under Section J (any falls since admission/entry) of the MDS if the resident has not had any falls since admission. The manual also instructed staff to code a one (1) under Section J if the resident had fallen since admission or prior assessment.

F 278 The DON or RN Supervisor will review at least five MDS's per week to ensure that the assessment is coded correctly. This will occur weekly for 4 weeks to identify any areas for improvement and monthly thereafter. Results of audits will be forwarded to the monthly CQI committee for further review and continued compliance.

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(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 278 Continued From page 6

F 278

Record review revealed the facility originally admitted Resident #1, on 06/29/13 with diagnoses which included Recurrent Gastro-Intestinal Bleed, Peptic Ulcer Disease, Anemia, Sacral Decubitus, Hypertension, Seasonal Allergies and Depressive Disorder. However, on 06/30/13 Resident #1 was transferred to an acute hospital due to a Gastro-Intestinal Bleed. The facility then re-admitted Resident #1, on 07/10/13.

Review of Resident #1's initial/admission MDS assessment revealed an ARD, of 07/17/13. Review of Section J (any falls since admission/entry or re-entry) revealed Resident #1 was coded as a zero (0), indicating he/she had not experienced any falls from the date of admission (07/10/13) to the ARD (07/17/13).

Review of the facility's fall investigation form, dated 07/14/13, revealed Resident #1 had experienced an unwitnessed no injury fall (slide from wheelchair), on 07/14/13 at 8:15 PM.

Review of Resident #1's plan of care, revealed a care plan with an onset date, of 06/29/13, which stated he/she would not have any unidentified complications related to falls. An intervention, dated 07/14/13, stated Resident #1 was to use a tilted back wheelchair with a low seat and rear anti-tips.

Interview with Physical Therapist #1, on 07/25/13 at 10:55 AM, revealed she recommended a low seat, tilted back wheelchair for Resident #1 as a safety intervention after a fall, on 07/14/13.

Interview with Licensed Practical Nurse (LPN) #3,

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 278 Continued From page 7
on 07/26/13 at 10:43 AM, revealed the facility defined a fall as any change in surface which included a slide from a wheelchair. LPN #3 stated, she believed Resident #1's fall on 07/14/13, should have been coded on the admission MDS.

Interview with the Acting Director of Nursing (DON), on 07/26/13 at 9:22 AM, revealed any unintentional change in position was considered a fall. The Acting DON stated the MDS nurses were to look at facility incident reports and logs to complete section J (falls) of the MDS. Therefore, she reported Resident #1's slide from his/her wheelchair on 07/14/13, should have been coded on his/her admission MDS assessment as a fall. The Acting DON reported Resident #1's admission MDS had been incorrectly coded under Section J (falls).

Interview with the Administrator, on 07/26/13 at 4:50 PM, revealed she expected staff to code a slide from a wheelchair to the floor as a fall on the resident's MDS assessment.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observations, interview, record review, and review of the facility's policy it was determined the facility failed to ensure services

F 278

F 281 It is the policy of Elliott Nursing & Rehabilitation Center (ENRC) that services provided or arranged by the facility must meet professional standards of quality.

09/06/2013

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(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 281 Continued From page 8 provided met professional standards of quality for two (2) of fifteen (15) sampled residents (Resident #1 and #4).

Resident #4 had Physician's order for oxygen to be administered at three (3) liters per minute (LPM). Observations revealed the resident's oxygen to be set at two (2) to two and one half (2.5) LPM.

There was no documented evidence of assessment and care planning sufficient to meet the needs of newly admitted Resident #1 related to his/her history of depression/suicidal ideations.

The findings include:

Interview with the Administrator on 07/26/13 at 5:00 PM, revealed there was no facility policy on following Physician's Orders. She stated her expectation was for nurses to follow Physician's Orders.

1. Review of the medical record for Resident #4 revealed the facility admitted the resident on 07/20/12 with diagnoses which included Congestive Heart Failure (CHF). Review of the Annual Minimum Data Set (MDS) Assessment, dated 07/02/13 revealed the facility assessed Resident #2 with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact. Further review of the MDS revealed the facility assessed Resident #2 to require the use of oxygen.

Review of the July 2013 monthly Physician's Order revealed an order for Resident #2 to have oxygen administered at three (3) liters per minute

F 281 On 7/26/13, the charge nurse readjusted Resident #4's oxygen to be administered at 3 liters per minute. The resident was counseled by the charge nurse on 7/26/13 regarding the importance of following physician orders for oxygen. The MDSC updated the care plan for resident #4 on 8/29/13 to reflect resident habit of changing the O2 settings.

On 7/26/13, Resident #1's care plan was updated by the Social Services Director to include appropriate interventions related to his/her history of suicide and his/her diagnosis of depression.

On 8/15/13 education was provided to the IDCPT and all licensed nursing staff by the Administrator regarding the importance of providing or arranging services that meet professional standards of quality. This included, but was not limited to, the importance of following physician orders as directed and utilizing the nursing process to assess and implement care planning decisions based on the individual needs of the resident.

The DON, RN Supervisor and LPN Charge Nurse will review all physician orders by 9/5/13 and ensure that the orders are implemented as directed. The IDCPT will review all care plans by 8/22/13 to ensure that the plan of care accurately and comprehensively reflects the current needs of each resident. Additionally, a review of care will be completed by the Administrator, DON and RN Supervisor via visual walking rounds no later than 8/29/13 to ensure that care and services are being provided according to professional standards of quality.

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

PRINTED: 08/09/2013
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 C 07/26/2013
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	
(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 281 Continued From page 9
(LPM).

Observations, on 07/23/13 at 2:07 PM, 4:15 PM, and 5:15 PM revealed Resident #4's oxygen to be set at two (2) LPM. Observations, on 07/24/13 at 9:12 AM, 10:00 AM, and 2:00 PM revealed the resident's oxygen to be set at two and one half (2.5) LPM. Observation, on 07/25/13 at 9:30 AM, revealed Resident #4's oxygen to be set at 2.5 LPM.

Interview, on 07/25/13 at 5:50 PM, with State Registered Nursing Assistant (SRNA) #4 revealed she was assigned to work on Resident #4's hall that day. She stated Resident #4's oxygen was supposed to be set on two (2) LPM. SRNA #4 stated she had asked the nurses before and they had told her the resident's oxygen was supposed to be set on two (2) LPM. SRNA #4 observed Resident #4's oxygen and stated it was set on 2.5 LPM at that time; however, should have been on two (2) LPM.

Interview, on 07/25/13 at 5:54 PM, with Licensed Practical Nurse (LPN) #1 revealed Resident #4's oxygen was supposed to be set on three (3) LPM. LPN #1 observed Resident #4's oxygen and stated it was set on 2.5 LPM; however, should have been on three (3) LPM as ordered.

Interview with the Administrator, on 07/26/13 at 5:00 PM, revealed her expectation was for nurses to follow Physician's Orders. She stated nurses should be checking Physician's Orders for what oxygen was supposed to be set on and ensuring that's what it (oxygen) was set on prior to signing it off on the Electronic Medication Administration Record (E-MAR).

2. Review of the facility's policy titled,

F 281 The DON, RN Supervisor and LPN Charge Nurse will review all physician orders by 9/5/13 and ensure that the orders are implemented as directed. The IDCPT will review all care plans by 8/22/13 to ensure that the plan of care accurately and comprehensively reflects the current needs of each resident. Additionally, a review of care will be completed by the Administrator, DON and RN Supervisor via visual walking rounds no later than 8/29/13 to ensure that care and services are being provided according to professional standards of quality. The DON, RN Supervisor or LPN Charge Nurse will review at least five resident records per week for four weeks, and monthly thereafter, to ensure that resident health information is being documented according to professional standards. Additionally, walking rounds will be conducted at least three times per week for four weeks, and weekly thereafter, to ensure that nursing care is being delivered in a manner that meets or exceeds professional standards of quality. The results of these audits and compliance rounds will be forwarded to the monthly CQI committee for further review and continued compliance.

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO 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 281 Continued From page 10

"Comprehensive Plan of Care", effective 08/01/12, revealed each resident would have an individualized plan of care by means of a written document. The policy stated all personnel providing care for a resident would have knowledge of and access to the resident's plan of care. The policy stated the Comprehensive Care Plan would describe the services that were to be furnished to attain/maintain the resident's highest practicable physical, mental and psychosocial well-being.

Record review revealed the facility originally admitted Resident #1, on 06/29/13 from the hospital, with diagnoses which included Recurrent Gastro-Intestinal Bleed, Peptic Ulcer Disease, Anemia, Sacral Decubitus, Hypertension, Seasonal Allergies and Depressive Disorder. However, on 06/30/13 Resident #1 was transferred to an acute hospital due to a Gastro-Intestinal Bleed. The facility then re-admitted Resident #1, on 07/10/13.

Record review revealed Resident #1 had an Order For Emergency Appointment of Fiduciary, on 06/26/13, due to a history of severe Depression and memory loss with an attempted suicide. Therefore, Resident #1 was ordered an individual guardian, on 06/26/13.

Review of Resident #1's Psychiatric Progress Notes from the prior hospitalization, dated 06/26/13, revealed the resident had been treated in an inpatient psychiatric facility due to a recent attempted suicide. The note stated Resident #1 had a diagnosis of Major Depressive Disorder. The note continued onto state Resident #1 was started on Remeron (antidepressant) medication daily.

F 281

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(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 281 Continued From page 11

F 281

Record review revealed a initial care plan dated, 06/29/13, which stated Resident #1 would have no unidentified complications related to medication usage/side effects related to the use of antidepressant medication. However, further review of Resident #1's current plans of care, revealed there was no care plan initiated upon admission with interventions that addressed the resident's diagnosis of Depression and/or the resident's history of suicidal ideation/attempt.

Review of the Physician's Orders, dated 07/12/13, revealed Resident #1 continued to be administered Remeron 7.5 milligrams (mgs) by mouth daily at bedtime for depression.

Review of Resident #1's admission Minimum Data Set (MDS) assessment, dated 07/17/13, revealed he/she had a Brief Interview for Mental Status (BIMs) score of four (4), this score indicated severe cognitive impairment. Review of Section D (Mood) of the MDS revealed Resident #1 continued to display depressive symptoms which included feeling down, depressed or hopeless nearly everyday. Resident #1's overall Depression Severity Score was six (6), this score indicated mild Depression. Review of Section I (Active Diagnoses) revealed Resident #1 had a current diagnosis of Depression.

Observation during a skin assessment, on 07/25/13 at 2:55 PM, revealed Resident #1 had red linear scars to his/her bilateral wrist.

Interview with State Registered Nursing Assistant (SRNA) #7, on 07/26/13 at 11:00 AM, revealed she normally worked with Resident #1 weekly. SRNA #7 reported she was not informed by the

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

PRINTED: 08/09/2013
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 C 07/26/2013
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	
(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)

F 281 Continued From page 12

facility of Resident #1's history of Depression and suicidal ideation/attempt. However, SRNA #7 stated Resident #1 had actually told her about his/her psychiatric history. SRNA #7 stated she was unaware of any care plans or interventions in place in regards to the resident's depression/suicidal attempt.

Interview with SRNA #10, on 07/26/13 at 11:10 AM, revealed she was a usual caregiver for Resident #1. SRNA #10 reported she was unaware Resident #1 had a recent history of self harm and Depression. SRNA #10 reported she was not aware of any interventions in place to prevent self harm or Depression.

Interview with Licensed Practical Nurse (LPN) #3, on 07/26/13 at 10:43 AM, revealed Resident #1 should be care planned related to his/her diagnosis of Depression and history of self harm. LPN #3 stated since Resident #1 had a recent history of self harm, he/she should have been monitored for signs/symptoms of Depression.

Interview with LPN #1, on 07/25/13 at 5:15 PM, revealed she was aware Resident #1 had slit his/her wrist in a suicide attempt prior to admission to the facility last month. LPN #1 reported Resident #1 should have been care planned related to prevention of suicidal ideations/self harm. LPN #1 stated with Resident #1's history of Depression and suicidal ideations, staff should be aware of the need to keep sharp objects out of reach. LPN #1 reported the nurses working the floor were responsible for the admission care plans, while the MDS nurses created and updated the comprehensive plan of care.

F 281

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(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 281 Continued From page 13

Interview with the Acting Director of Nursing (DON), on 07/26/13 at 9:22 AM, revealed she expected staff working with Resident #1 to be aware of his/her history of suicidal ideation and Depression. The Acting DON agreed Resident #1 should have a care plan in place that addressed goals related to his/her Depression. The Acting DON sated it was important to address Resident #1's Depression with a plan of care so everyone was aware of what the resident's needs were. The Acting DON added, that the resident's plan of care served as a good communication form between staff.

Interview with Resident #1's Physician, on 07/25/13 at 10:30 AM, revealed she expected Resident #1 to have a care plan in place that addressed his/her diagnosis of Depression. Resident #1's Physician reported it was important to monitor Resident #1's mood for signs and symptoms of Depression.

Interview with the Administrator, on 07/26/13 at 4:50 PM, revealed she expected resident's with a diagnosis of Depression and antidepressant use to be addressed in a plan of care. The Administrator stated proper care planning was important to address every resident's needs, both mental and physical.

F 281

F 309 483.25 PROVIDE CARE/SERVICES FOR
SS=D HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 309 It is the policy of Elliott Nursing & Rehabilitation Center

to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

09/06/2013

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309 Continued From page 14

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (1) of fifteen (15) sampled residents (Resident #1). Resident #1 was noted to have excoriation to his/her perineal area during skin assessment with the surveyor. This excoriation had not been reported to the nurse prior to the skin assessment with the surveyor. In addition, Resident #1's mental needs were not addressed as evidence by no individualized plan of care or interventions to address possible future depressive symptoms or future suicidal ideations.

The Findings Include:

1. Review of the facility's policy titled, "Wound Management Guidelines", effective 03/01/13, revealed the purpose of the policy was to provide guidelines to ensure the most appropriate care and treatment of skin issues. The policy stated residents would receive the appropriate treatment for their skin issues as identified.

Review of the facility's policy titled, "Risk

F 309 On 7/25/13, the physician saw Resident #1 and skin protective cream was ordered. The charge nurse recorded the order, documented family notification and applied the cream as indicated.

On 7/26/13, Resident #1's care plan was updated by the Social Services Director to include her history of suicidal ideations and depression. Appropriate interventions were recorded and communicated to all nursing staff via verbal report at each shift change and verbally communicated to primary care givers by the Social Services Director. This communication is on-going and follow up is occurring as needed by the Administrator and Social Services Director. By 8/2/13, the RN Supervisor completed skin assessments of all in house residents to ensure that there were no skin issues that had not been reported to the MD and licensed nursing staff. Any new issues identified were reported to the MD for appropriate orders and family notification was completed and recorded in the resident medical record. The IDCPT will review all resident care plans by 8/22/13 to ensure that each plan of care is reflective of current resident needs and that appropriate interventions are recorded so that each resident can attain or maintain the highest practicable physical, mental, and psychosocial well-being.

On 7/26/13 the Social Services Director was re-educated by the Administrator regarding the importance of developing a comprehensive plan of care so that services can be provided to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being

09/06/2013

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

PRINTED: 08/09/2013
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 C 07/26/2013
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	

F 309 Continued From page 15

Assessment Scale and Documentation", effective 03/01/06, revealed any change of skin condition or abnormalities would be reported to and assessed by a nurse.

Review of the facility form titled, "Stop and Watch Early Warning Tool", dated 01/13, revealed when staff members identified changes such as those in skin color or condition, they were to indicate the change observed on the form, and then review the change with the nurse as soon as possible. The form contained an area for the resident's name, staff reporting, as well as date, time and who the change was reported to.

Record review revealed the facility originally admitted Resident #1, on 06/29/13 with diagnoses which included Recurrent Gastro-Intestinal Bleed, Peptic Ulcer Disease, Anemia, Sacral Decubitus, Hypertension, Seasonal Allergies and Depressive Disorder. However, on 06/30/13 Resident #1 was transferred to an acute hospital due to a Gastro-Intestinal Bleed. The facility then re-admitted Resident #1, on 07/10/13.

Review of Resident #1's admission Minimum Data Set (MDS) assessment, dated 07/17/13, revealed he/she had a Brief Interview for Mental Status (BIMs) score of four (4), this score indicated severe cognitive impairment. Review of Section G (functional status) of the MDS, revealed Resident #1 required the assistance of two staff members with bed mobility, transfers, walking in room, dressing, and toileting. This section also indicated Resident #1 required the assistance of one staff member for eating, bathing and personal hygiene. Section H (Bladder and Bowel) of the MDS revealed Resident #1 was

F 309 On 8/15/13 the Administrator provided additional education to all members of the IDCPT regarding the importance of ensuring that each resident care plan is reflective of current needs in order to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The DON, RN Supervisor and LPN Charge Nurse will provide education to all nursing staff by 8/19/13 regarding the importance of providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with the resident's comprehensive plan of care. The education included, but was not limited to, reporting any changes in resident condition to the nursing supervisor and appropriate notification of MD and family. Licensed staff received additional education regarding the importance of capturing resident needs on the admission care plan and the utilization of short term care plans for acute issues. The DON or RN Supervisor will complete body audits on at least five residents per week for four weeks, and at least five residents monthly thereafter, to ensure that all skin issues are identified, receive appropriate treatment orders and that MD and family notification occur per facility policy.

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

PRINTED: 08/09/2013
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 C 07/26/2013
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	
(X4) IO 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)

F 309 Continued From page 16
occasionally incontinent of urine and always incontinent of bowel.

Review of Resident #1's Comprehensive Plan of Care (POC), initiated 06/29/13, revealed he/she was incontinent of bowel and bladder. The goal of the POC was for Resident #1 to be free from unidentified infections from incontinence through next review, of 09/29/13. As part of the interventions listed, Certified Nursing Assistants (CNAs) were to observe Resident #1's skin daily for irritation and redness with daily care. Observations of irritation and redness to Resident #1's skin were to be reported to the nurses.

Observation of Resident #1's head to toe skin assessment performed by Licensed Practical Nurse (LPN #1), on 07/25/13 at 2:55 PM, revealed he/she had redness and excoriation to his/her perineal area and inner thighs. Interview with LPN #1, during the skin assessment revealed she was unaware of redness/excoriation to the resident's perineal area. LPN #1 reported Resident #1 required assistance with toileting and was incontinent at times, so he/she wore a brief.

Review of Resident #1's Physician's Orders revealed there were no treatments in place to address redness/excoriation to his/her perineal area prior to the skin assessment observed by the surveyor on 07/25/13.

Review of a Physician's Note, dated 07/25/13 at 9:55 PM, revealed after the skin assessment observed by the surveyor, Resident #1 was seen by the Physician due to reports of redness/irritation to his/her groin area. The Physician's notes stated Resident #1's groin and inner thighs were red with a "yeasty appearing

F 309 The DON or RN Supervisor will audit all admission care plans for four weeks, and at least two per week thereafter, to ensure that care plans are implemented in a manner that provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being.

The DON will utilize walking rounds and chart reviews to identify any other areas of concern regarding the Quality of Care delivered to the residents at our facility. Walking rounds will be completed three times per week for four weeks and at least weekly thereafter. Two random chart reviews will be conducted weekly for four weeks and at least one per week thereafter to ensure that care and services provided are provided so that the resident can attain or maintain his/her highest practicable level of well-being.

The results of these audits will be forwarded to the monthly CQI committee for further review and continued compliance.

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 17 rash."</p> <p>Interview with State registered Nursing Assistant (SRNA) #8, on 07/25/13 at 3:30 PM, revealed she had changed Resident #1's brief prior to the skin assessment observed by the surveyor. SRNA #8 stated she noticed Resident #1's perineal area was red, but she was unsure wether or not this was a normal skin condition for this resident, so she did not report the redness to the nurse. SRNA #8 also stated she believed the nurses may have already had a treatment in place for the redness, but she was unsure.</p> <p>Interview with SRNA #9, on 07/25/13 at 4:39 PM, revealed she had provided incontinence care to Resident #1 prior to the skin assessment observed by the surveyor. SRNA #9 reported Resident #1's perineal area was red earlier that day while she was providing care. SRNA #9 reported she did not inform the nurses of the change in Resident #1's skin condition, because she was unsure if the redness was "normal" for him/her. SRNA #9 reported she was supposed to report any change in a resident's skin condition to a nurse.</p> <p>Interview with SRNA #10, on 07/26/13 at 11:10 AM, revealed she had noticed Resident #1 had redness of his/her perineal area, on 07/25/13. However, SRNA #10 reported she did not tell the nurse of the skin condition. SRNA #10 stated she should have told the nurse about the redness to Resident #1's perineal area. SRNA #10 stated it was important to inform the nurse of changes in skin condition so treatment could begin.</p> <p>Interview with LPN #3, on 07/26/13 at 10:43 AM, revealed SRNA's should report any changes in a</p>	F 309	
-------	--	-------	--

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309 Continued From page 18

resident's skin condition directly to the nurse.

Interview with the Acting Director of Nursing (DON), on 07/26/13 at 9:22 AM, revealed the SRNA's providing perineal care for Resident #1 should have verbally told the nurse as soon as possible when they noticed the excoriation/redness. The Acting DON stated it was important to inform the nurse to ensure the Resident's problem was identified and received treatment as soon as possible. The Acting DON, stated the Stop and Watch forms were also used for to report anything abnormal. However, the Acting DON stated verbally informing the nurses of changes in a resident's condition was sufficient.

Interview with the Administrator, on 07/26/13 at 4:50 PM, revealed she expected the SRNA's to immediately inform the nurse when they notice a change in the resident's skin condition. The Administrator stated verbal communication was sufficient, and that Stop and Watch forms could be used in addition, but was not required.

2. Record review revealed the facility admitted Resident #1, on 06/29/13 with diagnoses which included Recurrent Gastro-Intestinal Bleed, Peptic Ulcer Disease, Anemia, Sacral Decubitus, Hypertension, Seasonal Allergies and Depressive Disorder. However, on 06/30/13 Resident #1 was transferred to an acute hospital due to a Gastro-Intestinal Bleed. Resident #1 was then re-admitted to the facility, on 07/10/13 from an acute care hospital.

Record review of Resident #1's Psychiatric Progress Notes, dated 06/26/13, revealed the resident had received psychiatric treatment due

F 309

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309 Continued From page 19

to a recent attempted suicide. The progress note also revealed Resident #1 had a diagnosis of Major Depressive Disorder. Lastly, the note continued onto state Resident #1 was started on Remeron (antidepressant) medication daily.

Record review revealed Resident #1 was issued an Order For Emergency Appointment of Fiduciary, on 06/26/13, due to a history of severe Depression and memory loss with an attempted suicide. On 06/26/13, Resident #1 was issued an individualized guardian.

Record review revealed there was no care plan initiated upon admission or re-admission with interventions that addressed the Resident's diagnosis of Depression and/or the resident's history of suicidal ideation/attempt.

Review of the Physician's Orders, dated 07/12/13, revealed Resident #1 continued to be administered Remeron 7.5 milligrams (mgs) by mouth daily at bedtime for depression.

Review of Resident #1's initial Minimum Data Set (MDS) assessment, dated 07/17/13, revealed he/she had a Brief Interview for Mental Status (BIMs) score of four (4). A score of four (4) indicated severe cognitive impairment. Review of Section D (Mood) of the MDS revealed Resident #1 displayed depressive symptoms which such as feeling down, depressed or hopeless nearly everyday during the review period. Resident #1's overall Depression Severity Score was six (6), which indicated mild Depression. Review of Section I (Active Diagnoses) revealed Resident #1 had an active diagnosis of Depression.

Observation, on 07/25/13 at 2:55 PM, during a

F 309

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 20</p> <p>skin assessment revealed Resident #1 had red linear scars to his/her bilateral wrist.</p> <p>Interview, on 07/26/13 at 11:00 AM, with State Registered Nursing Assistant (SRNA) #7 revealed she normally worked with Resident #1 weekly. SRNA #7 reported the facility had never informed her of Resident #1's history of Depression and suicidal attempt. Although, SRNA #7 stated Resident #1 had actually told her about his/her psychiatric history. SRNA #7 stated she was unaware of interventions in place at the facility to address the resident's history of depression/suicidal attempt.</p> <p>Interview, on 07/26/13 at 11:10 AM, with SRNA #10 revealed she was a usual caregiver for Resident #1. SRNA #10 reported she had no knowledge of Resident #1's recent history of self harm and Depression. SRNA #10 reported she unaware of any interventions in place to prevent Resident #1 from self harm or Depression.</p> <p>Interview, on 07/26/13 at 10:43 AM, with Licensed Practical Nurse (LPN) #3 revealed Resident #1 should have been care planned related to his/her diagnosis of Depression and history of self harm. LPN #3 stated Resident #1 had a recent history of self harm, so he/she should be monitored for signs/symptoms of Depression.</p> <p>Interview, on 07/25/13 at 5:15 PM, with LPN #1 revealed she was aware Resident #1 had recently slit his/her wrist in a suicide attempt prior to admission to the facility. LPN #1 stated with Resident #1's history of Depression and suicidal ideations, staff should be aware of the need to keep sharp objects out of reach. LPN #1 reported the nurses working the floor were responsible for</p>	F 309
-------	--	-------

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

PRINTED: 08/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">185415</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">C 07/26/2013</p>
--	---	--	---

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
--	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	Continued From page 21 initiating the admission care plans, while the MDS nurses were responsible for creating and updating the comprehensive plans of care. Interview, on 07/26/13 at 9:22 AM, with the Acting Director of Nursing (DON) revealed she expected personnel with Resident #1 to be informed of his/her history of suicidal ideation and Depression. The Acting DON agreed Resident #1 should have goals and interventions in place that addressed related to his/her Depression. The Acting DON stated it was important for everyone to be aware of what the resident's needs were. Interview with Resident #1's Physician, on 07/25/13 at 10:30 AM, revealed it was important to monitor Resident #1 for signs and symptoms of Depression. Interview with the Administrator, on 07/26/13 at 4:50 PM, revealed proper care planning was important to address every resident's needs; both mental and physical.	F 309		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	It is the policy of Elliott Nursing & Rehabilitation Center (ENRC) to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order is maintained and periodically reconciled. Drugs and biological used in the facility must be labeled in accordance with currently accepted professional principles, and cautionary instructions, and the expiration date when applicable.	09/06/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/09/2013
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 C 07/26/2013
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	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 431	<p>Continued From page 22 appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>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 ensure biologicals were not expired in accordance with currently accepted professional principles.</p> <p>Observation of the Lighthouse (a locked unit) medication room during initial tour on 07/26/13 at 1:20 PM revealed biologicals which were expired.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Medication Storage in the facility", undated, revealed "Outdated, contaminated, or deteriorated</p>	F 431	<p>On 7/23/13 all biologicals that were out dated were removed from use by the RN Supervisor.</p> <p>On 7/24/13 all biologicals were audited by the DON and RN Supervisor to ensure that any expired biologicals had been discarded. No other expired supplies were identified. By 8/22/13 all licensed nursing staff will be re-educated by the DON and RN Supervisor regarding the proper dating and labeling of all drugs and biological in accordance with currently accepted professional principles, cautionary statements and expiration dates, when applicable.</p> <p>Additional education will include the importance of maintaining our system regarding the receipt and disposition of controlled drugs in sufficient detail to ensure accurate periodic reconciliation.</p> <p>The central supply room biologicals will be audited by our Medical Records Director monthly for proper dating and expiration. The DON/RN Supervisor will audit the medication room, med carts, and treatment carts weekly for 4 weeks to ensure all medications and biologicals are appropriately labeled in accordance with accepted professional principles, dated, and that expiration date is recorded, if applicable. Thereafter the DON or RN Supervisor will perform a monthly audit of all drugs and biologicals for labeling, dates and expiration dates in order to ensure continued compliance. The consulting pharmacist will also review med rooms and carts to ensure that drugs and biologicals are labeled and dated according to current accepted professional principles. Results of audits will be forwarded to Quality Improvement committee for further review and continued compliance.</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415		IX2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		IX3) DATE SURVEY COMPLETED C 07/26/2013	
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			
(X4) IO 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 431	Continued From page 23 medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock." Observation, on 07/26/13 at 1:20 PM, of the Lighthouse Unit medication room revealed the following items to be outdated per dates on the item packaging: A full box and a partial box of "Protime 3" (tests the thickness of blood to titrate sliding scale blood thinner medication) test units dated 03/2013 A cannister of "Dispatch" wipes (a sanitizing, disposable cloth) dated 12/01/2012 Individual Betadine swab sticks (a skin cleanser) dated 08/2011 (12 packs) 0.9% Normal Saline 120 Millileters (ml) dated 03/2013 (10 containers) A full box of Hemocult test slides (used to test feces for blood), dated 10/2012 An enema bag dated 11/2011 Yankauer suction tips (2), dated 12/2012 Steri Strip 1/8" skin closures (10) dated 02/2011 Spring water (2 gallon jugs) dated 03/27/11 Interview, on 07/26/13 at 1:45 PM, with the House Supervisor (also facility Educator) that was working the Lighthouse Unit this day revealed she had assumed the usual nurse in charge of the unit (on vacation) was either checking for expiration dates or was having her staff do it.			F 431			

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(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 431 Continued From page 24
Further interview revealed that, she, as the facility Educator, did general staff education but the unit charge nurses did unit specific education. Continued interview revealed the facility had a stock clerk to restock supplies and check for outdates until about seven (7) months ago, when that position was eliminated.

F 431

Interview, on 07/26/13 at 5:00 PM, with facility Administrator revealed it was the Lighthouse unit staff responsibility to re-stock supplies and check for outdates. Further interview revealed there was not a formal process in place to check for outdates.

F 441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441 It is the policy of Elliott Nursing & Rehabilitation Center 09/06/2013

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and 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.

(ENRC) to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

On 7/25/13, the RN Supervisor re-educated LPN #1, LPN #2 and SRNA #6 regarding proper glove use and proper hand washing techniques per the Infection Control policies.

The Infection Control Log was reviewed by the DON on 8/15/13. A look back period of six months indicated that no resident had been adversely affected by this deficient practice.

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441 Continued From page 25

(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 facility's policy, it was determined the facility failed to maintain an Infection Control (IC) program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for two (2) of fifteen (15) sampled residents (Residents #1 and #2) as evidenced by failure to remove soiled gloves, wash hands, and don new gloves during skin assessments after assessing residents perineal and buttock area.

Observation during Resident #1's and #2's head to toe skin assessment revealed the nurses assessed contaminated areas with their gloved hands and proceeded to assess other areas of the residents' bodies without removing the contaminated gloves, washing their hands, and donning new gloves.

In addition, observation during a dinner meal

F 441 All nursing staff will be reeducated 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. This reeducation will be provided by the DON and RN Supervisor and will be completed by 8/23/13. However, on-going education regarding specific topics each month will be presented to staff by the DON and RN Supervisor.

The DON/RN Supervisor will visually monitor via daily compliance rounds (Monday- Friday) various aspects of the infection control program at least 3 times per week for 4 weeks and once a week ongoing. These compliance rounds will focus on all aspects of infection control but each month, a single practice such as appropriate techniques for skin assessments or hand washing, will be the feature topic. Staff will receive additional education on the featured topic and visual audits will be directed towards the monthly featured topic.

In addition, the DON/RN Supervisor will complete random observation of hand washing before, during, and after skin assessments and during meals per the Infection Control Policies. Any violation will be addressed with one-on-one education.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/09/2013
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 C 07/26/2013
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	
(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)
F 441	Continued From page 26 revealed a State Registered Nursing Assistant (SRNA) delivering and setting up trays in residents rooms. Observation revealed the SRNA to wear gloves which she changed; however, did not wash or sanitize her hands after removal of her gloves. The findings include: Review of the facility's policy, "Handwashing/Hand Hygiene", dated 08/12 revealed the facility considered hand hygiene the primary means to prevent the spread of infections. Review revealed all staff were to follow handwashing/hand hygiene procedures to help prevent the spread of infections to other residents, staff or visitors. Continued review of the policy revealed staff were to wash their hands after direct resident contact and after contact with a resident's mucous membranes, body fluids or excretions. Review revealed staff were to wash or sanitize their hands after removal of gloves. Further review revealed the use of gloves did not replace handwashing/hand hygiene. 1. Observation, on 07/25/13 at 2:55 PM, of Resident #1's head to toe skin assessment, performed by Licensed Practical Nurse (LPN) #1 revealed during the assessment LPN #1 assessed Resident #1's perineal area, touching his/her inner thighs and perineal area with gloved hands. After assessing the resident's perineal area, LPN #1 rolled the resident to his/her left side and continued to assess Resident #1's buttocks. LPN #1 did not change gloves or wash her hands and touched the outside of the resident's wound vac dressing to his/her coccyx with the same gloves worn to assess the perineal area and buttocks. LPN #1 then rolled Resident	F 441	The results of the daily compliance rounds and the random observations will be forwarded to the monthly Quality Improvement committee meeting for further review and continued compliance.

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO 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 27</p> <p>#1 to his/her right side and secured his/her brief and adjusted the resident's gown. LPN #1 proceeded to reposition Resident #1 wearing the same gloves. LPN #1 removed her gloves, but did not wash her hands and continued to adjust Resident #1's pillow, gown and blanket.</p> <p>Interview, on 07/25/13 at 5:15 PM, with LPN #1 revealed she had received training at the facility regarding proper techniques to perform a head to toe skin assessment. LPN #1 stated she was instructed to assess the residents from the "cleanest to dirtiest" areas. LPN #1 stated she was to begin skin assessments by assessing the resident's head, arms, torso, back, legs, then perineal area. LPN #1 stated she should have changed gloves/washed hands after assessing Resident #1's perineal area and buttocks before touching other parts of the resident's body. LPN #1 stated proper infection control practices were important during skin assessments to prevent introducing bacteria to other areas of the resident's body.</p> <p>2. Observation, on 07/25/13 at 3:22 PM, of Resident #2's head to toe skin assessment, performed by LPN #2 revealed during the assessment LPN #2 assessed the resident's buttocks, spreading the cheeks to observe the anal area. Observation revealed LPN #2 then continued assessing other areas of the resident's body without removing the contaminated gloves, washing her hands and donning new gloves.</p> <p>Interview, on 07/25/13 at 5:02 PM, with LPN #2 revealed she did not feel she should have removed her gloves and don new gloves after she assessed Resident #2's buttock area. She</p>	F 441		
-------	--	-------	--	--

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

PRINTED: 08/09/2013
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 C 07/26/2013
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		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 28 stated she didn't come in contact with anything she felt would be a danger to herself or the resident. The LPN stated if she didn't come in contact with bodily fluids she didn't change her gloves. According to the LPN, if you came in contact with anything "dirty" such as, bodily fluids, feces, spit, open areas or urine then you would change your gloves. the contaminated gloves after assessing Resident #2's perineal area and buttocks, washed her hands and donned new gloves before proceeding with other areas of the body. 3. Observation, on 07/23/13 at 4:55 PM, of State Registered Nursing Assistant (SRNA) #6 revealed her delivering dinner meat trays to residents' rooms with gloves on. Continued observation revealed she changed her gloves from room to room, however did not wash or sanitize her hands after removal of her gloves and prior to donning new gloves. Interview, on 07/25/13 at 5:15 PM, with SRNA #6 revealed she should have washed or sanitized her hands before donning new gloves. She stated she knew to do this, however didn't know why she didn't do it. Interview, on 07/26/13 at 9:22 AM, with the Acting Director of Nursing (DON)/Infection Control Nurse revealed staff were expected to perform skin assessments using a "clean to dirty" method. The Infection Control Nurses/Acting DON added, staff were expected to wash their hands and change gloves after assessing the resident's perineal area and before assessing other areas of the resident's body. In addition, the Acting DON/Infection Control Nurse reported staff were in-serviced at least annually on proper infection	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELLIOTT NURSING AND REHABILITATION CENTER

RT 32 EAST, HOWARD CREEK RD
SANDY HOOK, KY 41171(X4) IO
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)IO
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETION
DATE

F 441 Continued From page 29
control techniques. The Acting DON/Infection Control Nurse stated it was important to follow proper infection control techniques during skin assessments to prevent the spread of infection to other areas of the body.

F 520 483.75(o)(1) QAA
SS=E COMMITTEE-MEMBERS/MEET
QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:

F 441

F 520

It is the policy of Elliott Nursing & Rehabilitation Center to maintain a Quality Assessment and Assurance Program that develops and implements appropriate plans of action to correct quality deficiencies. On 8/29/13 the Regional Quality Improvement Nurse will reeducate all members of the Quality Improvement Committee regarding proper development, implementation and follow-up of action plans. She will also discuss the importance of follow-up on all identified deficiencies to ensure these issues are resolved. On 8/02/13, all CQI minutes including action plans beginning January 2013 to current were audited by the Administrator and the Quality Improvement Committee Chairman to ensure that appropriate action plans were initiated based upon tracking and trending of identified issues. Action Plans were also reviewed to ensure that appropriate follow-up was completed until the problems resolved. Audits have been implemented in the specific areas with repeat deficiencies identified in the 2013 annual survey process. These deficient areas will continue to be audited on a monthly basis until resolution has occurred or the next annual survey has occurred.

09/06/2013

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

PRINTED: 08/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415	IX2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	IX3) DATE SURVEY COMPLETED C 07/26/2013
--	--	--	---

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
---	--

IX4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IX5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520 Continued From page 30

Based on observation, interview and record review, it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to ensure there was an effective infection control program, and failure to ensure professional standards of practice in following Physician's orders, and failure to ensure biologicals were not expired in accordance with currently accepted professional principles.

The findings include:

1. Based on interview and record review, it was determined the facility failed to ensure Physician's Orders were followed. This was a repeat deficiency for the facility which was cited 07/20/12 related to a resident having Physician's orders for notification of the Physician if the resident received less than three hundred sixty (360) cubic centimeters (cc's) of tube feeding.

Review of the facility's Plan of Correction, with a compliance date of 08/31/12, revealed Physician's orders for all residents were reviewed by the DON/RN Supervisor/Charge Nurse for all current residents and then reviewed again to ensure Physician's orders had been noted and implemented as written by the Physician. Education was provided to all licensed nursing staff regarding the importance of following Physician's orders as directed including notification of the Physician. Additionally, the DON/RN Supervisor were to review ten (10) Physician's orders per week for four (4) weeks to ensure orders had been received, noted and

F 520 Effective 8/02/13, the Quality Improvement Committee will continue to follow-up on all other action plans until the problem has proved to be resolved for a minimum of 12 weeks.

Effective 8/02/12, any resolved action plans will be added to the bi-yearly Quality Improvement Committee calendar for bi-annual follow-up by observation and/or audit of the identified issue to ensure ongoing compliance.

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	---	--	---

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
--	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520 Continued From page 31

implemented as directed by the Physician. The results of the audit were to be taken to CQI for further monitoring and continued compliance.

Observation during the current survey revealed Resident #4's oxygen to be set on two (2) to two and one half (2.5) liters per minute (LPM). Review of the record revealed a Physician's order for Resident #4's oxygen to be set on three (3) LPM.

Interview, on 07/26/13 at 5:00 PM with the Administrator revealed education had been provided as indicated on the previous Plan of Correction (PoC). She stated all orders were gone over right away, discussed in the Monday through Friday morning meeting and in the Continuous Quality Improvement (CQI) Committee. She stated the audits were completed as indicated on the previous PoC. Additionally, she stated her expectations were that nurses look at oxygen orders and ensure the oxygen is set correctly before signing off on the Electronic Medication Administration Record (E-Mar).

2. Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to ensure biologicals were not expired. This was a repeat deficiency for the facility which was cited 07/20/12 related to medications and biologicals opened and undated on medication and treatment carts.

Review of the facility's Plan of Correction, with a compliance date of 08/31/12, revealed the DON and Consultant Pharmacist audited all medications and biologicals were properly dated. The DON educated all licensed nursing staff

F 520

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520 Continued From page 32 regarding the proper dating of all drugs and biologicals. The Consultant Pharmacist was to audit all medications to ensure proper dating. The DON/RN Supervisor audited the medication rooms, medication carts, and treatment carts for four (4) weeks to ensure proper dating of medications. Monthly audits were performed after that by the DON/designee to ensure continued compliance. Results of the audits were to be taken to CQI for further review and continued compliance.

F 520

Observation during initial tour revealed numerous expired biologicals in the medication room of the specialized memory care Unit.

Interview, on 07/26/13 at 5:00 PM with the Administrator revealed education had been provided as indicated on the previous Plan of Correction (PoC). She stated a "sweep" had been done of the Central Supply area to ensure there were no expired products. The Administrator stated the auditing had been performed as per the previous PoC and the results taken to CQI for further monitoring, however there had been no new action plans developed in regards to this area. She indicated staff were to monitor for expired products on the specialized memory care unit. However, she stated there was no formal process in place for the monitoring of expired biologicals.

3. Based on observation, interview, and record review, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and infection within the facility. This was a repeat deficiency for the facility which was cited 07/20/12 related to a

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520

Continued From page 33
nurse placing the nasal cannula in Resident #3's nostrils with her bare hands and exiting the room without washing her hands; during incontinence care for a resident staff failed to wash hands after performing incontinence care and prior to touching objects in the room and failed to wash their hands prior to exiting the room after the incontinence care; a nurse performing incontinence care and then without washing her hands performing a dressing change; observation of perineal care for two residents revealed poor infection control technique; observation of staff were repeatedly placing the ice scoop back inside the ice chest, on top of the ice during ice pass.

F 520

Review of the facility's Plan of Correction, with a compliance date of 08/31/12, revealed nursing management nursing staff were reeducated regarding proper hand washing technique before, during, and after incontinence care; and on the proper use and positioning of the ice scoop. The facility alleged the Director of Nursing (DON) Registered Nurse (RN) Supervisor would visually monitor via daily compliance rounds Monday thru Friday various aspects of the infection control program three (3) times per week for four (4) weeks and once a month ongoing. Additionally, the DON/RN Supervisor was to complete random observations of hand washing before, during and after incontinence care and for the proper use of the ice scoop. Results of the audits were to be taken to CQI for further review and continued compliance.

Observations during the survey revealed the following: Observation of two (2) different nurses during head to toe skin assessments touching contaminated parts of the residents' bodies and proceeding to assess other areas without

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

PRINTED: 08/09/2013
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 C 07/26/2013
--	--	--	---

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
---	--

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520 Continued From page 34
removing the contaminated gloves, washing their hands and donning new gloves.

Also, observation during a dinner meal revealed a State Registered Nursing Assistant delivering and setting up food trays to resident rooms with gloved hands. Observation revealed the SRNA to remove her gloves and don new gloves without washing or sanitizing her hands.

Interview, on 07/26/13 at 5:00 PM with the Administrator revealed extensive education had been provided to nursing staff regarding infection control. She stated the facility had someone come from a sister facility and identify problems with infection control. The Administrator stated infection control was continually being looked at through their Continuous Quality Improvement (CQI) Committee. According to the Administrator, three infection control inservices were done with return demonstration. She stated the RN Supervisor monitors and audits for infection control issues during rounds Monday through Friday. The Administrator indicated staff should ensure proper infection control measures were performed during skin assessments and meal tray delivery.

F 520

08/16/2013 14:41 16067389410

A

PAGE 02/05

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

PRINTED: 08/09/2013
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2013
--	--	--	--

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
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS 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 07/24/13. Elliot Nursing and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was seventy one (71). The facility is licensed for seventy five (75) beds. The Highest Scope and Severity deficiency was a "F" level.	K 000		
-------	--	-------	--	--

RECEIVED
AUG 19 2013
BY: _____

K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		
---------------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Jacobella St* TITLE: Administrator DATE: 8/16/13

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.

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

PRINTED: 08/09/2013
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2013
--	--	--	--

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
---	--

(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 029 Continued From page 1
fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, sixty two (62) residents, staff and visitors.

The findings include:

Observation on 07/24/2013 at 1:31 PM, revealed the Maintenance Room next to the Maintenance Office had penetrations around the duct work and piping. The Maintenance Room contained a fuel fired water heater. Further observations revealed the Maintenance Room for 100 Hall and the Maintenance Room across from the Nursing Station contained fuel fired water heaters and had penetrations. The observations were confirmed with the Maintenance Director.

Interview on 07/24/2013 at 1:31 PM, with the Regional Maintenance Director, revealed the facility Maintenance Director was responsible for

K 029 compliance at all times.
On 8/6/13 the Regional Maintenance Director educated the facility Maintenance Director regarding the importance of inspecting all smoke resisting partitions for penetrations. Areas of penetration were repaired by the Regional Maintenance Director and the facility Maintenance Director on 8/15/13. All smoke resisting partitions were inspected on 8/15/13 by the facility Maintenance Director to assure no other penetrations existed. All identified issues have been addressed. The facility Maintenance Director will audit all smoke resisting partitions for penetrations on a weekly basis for 4 weeks to identify any areas for improvement and monthly ongoing. The results of these audits will be forwarded to the monthly CQI committee for further review and continued compliance.

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

PRINTED: 08/09/2013
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2013
--	--	--	--

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
---	--

(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 029 Continued From page 2
inspected Hazardous Area Rooms monthly for penetrations and the rooms should not contain any penetrations.

The findings were confirmed with the Administrator at the exit conference on 07/24/2013.

Reference: NFPA 101 (2000 edition)
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:
(1) Boiler and fuel-fired heater rooms
(2) Central/bulk laundries larger than 100 ft2 (9.3 m2)
(3) Paint shops
(4) Repair shops
(5) Soiled linen rooms
(6) Trash collection rooms
(7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction
(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.
Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more

K 029

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

PRINTED: 08/09/2013
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2013
--	--	--	--

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
---	--

(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 029	Continued From page 3 than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors equipped with delayed egress hardware had signage of the proper height, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, seventy five (75) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 07/24/2013 between 2:06 PM and 2:42 PM, reveled all exterior exit doors equipped with delayed egress located on the 100 Hall, 200 Hall, 300 Hall and Light House Unit had signage indicating the proper door operation with letters less than 1 inch in height. The observations were confirmed with the Regional Maintenance Director. Doors having delayed egress hardware must have signage meeting height and brush stroke width requirements.</p>	K 038	<p>It is the policy of Elliott Nursing & Rehabilitation Center (ENRC) that exit access is arranged so that exits are readily accessible at all times.</p> <p>On 7/24/13 the Regional Maintenance Director ordered signage with letters 1 inch in height for all exterior exit doors equipped with delayed egress.</p> <p>On 8/7/13 the Maintenance Director put up the new signage on all exterior exit doors equipped with delayed egress.</p> <p>An environmental audit was conducted by the Regional Maintenance Director and the Maintenance Director on 8/6/13 to identify any areas of further concern regarding exit access. All identified issues have been addressed.</p> <p>The Maintenance Director will audit the egress doors monthly to ensure the delayed egress door signage is in place. The Administrator will audit a sample of egress doors monthly for delayed egress signage. The results of these audits will be forwarded to the monthly CQI committee for further review and continued compliance.</p>	09/6/2013

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

PRINTED: 08/09/2013
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2013
--	--	--	--

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
---	--

(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 038 Continued From page 4
Interview on 07/24/2013 at 2:06 PM, with the Regional Maintenance Director, revealed the signs had been installed recently and the facility was unaware the signage did not meet Life Safety Code requirements.
The findings were confirmed with the Administrator at the exit conference on 07/24/2013.

K 038

K 104 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.

K 104 It is the policy of Elliott Nursing & Rehabilitation Center that penetrations of smoke barriers by ducts are protected in accordance with 8.3.6
09/6/2013

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure fire dampers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, seventy five (75) residents, staff and visitors.

The findings include:
Observation on 07/24/2014 at 1:29 PM, revealed the Male/Female Public Restroom had fire dampers controlled by a fusible link. Further observation revealed a total of forty two (42) fire dampers controlled by fusible links in the facility. The observations were confirmed with the Regional Maintenance Director.

Interview on 07/24/2014 at 1:29 PM, with the Regional Maintenance Director, revealed the

On 7/24/13 the Regional Maintenance Director ordered dampers from Sentry Fire. Maintenance will be performed and finalized by 9/6/13. Facility audit was completed by the Regional Maintenance Director and the facility Maintenance Director on 8/15/13 to identify if all fusible links had been changed per regulation within 4 years. Any areas identified will be corrected by 9/6/13.
The Regional Maintenance Director educated the facility Maintenance Director on 8/6/13 regarding the importance for monitoring fire dampers to ensure the fusible links are replaced every 4 years and maintenance is performed to ensure proper operation.
The Maintenance Director will conduct monthly audits for compliance of fire damper maintenance as a routine monthly preventative task.

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

PRINTED: 08/09/2013
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2013
--	---	--	---

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
--	--

(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 104 Continued From page 5
facility had no documentation for maintenance and inspection of the fire dampers. Fire dampers must be maintained to prevent the spread of fire.

The findings were confirmed with the Administrator at the exit conference on 07/24/2013.

Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.

K 104 The results of these audits will be forwarded to the monthly CQI committee meeting for further review and continued compliance.