

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

*Acceptable
POC
7/20/13*

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	
(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 000 INITIAL COMMENTS

A Recertification Survey was initiated on 06/11/13 and concluded on 06/13/13. Deficiencies were cited with the highest Scope and Severity of a "E".
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.

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

F 000

Disclaimer for Plan of Correction

Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Kentucky Medical Investors Ltd., d/b/a Laurel Creek Health Care Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Kentucky Medical Investors Ltd., d/b/a Laurel Creek Health Care Center files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicaid/Medicare Program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction would not be taken as establishing any standard of care, and the facility submits that the actions by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal, or equitable, in administrative, civil or criminal proceeding.

RECEIVED
JUL 16 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Clara Benz
TITLE
Director
(X6) DATE
07-05-13

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: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2013
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962		
(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	F 157			
	<p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy regarding Physician Notification, it was determined the facility failed to notify the physician for clarification for an antibiotic medication that was ordered for one (1) of twenty (20) sampled residents (Resident #5). The medication Vancomycin was ordered in capsule form; however, was changed by the pharmacy to liquid form and administered to the resident.</p> <p>The findings include:</p> <p>Review of the facility policy regarding "Physician's Orders/Transcription", revised October 2004, revealed5. When an order is changed, treat old order as if it had been discontinued. Write the change order in a new block and treat it as a new order.</p> <p>Observation of the medication pass, on 06/12/13 at 12:15 PM, revealed Resident #5 received the antibiotic medication Vancomycin 250 mg (5ml) by mouth. Reconciliation of the medication revealed physician's orders, on 05/31/13, for Vancomycin 250 mg capsule (1) to be given every eight (8) hours for fourteen (14) days.</p> <p>Interview with the Medication Nurse, Licensed Practical Nurse (LPN) #1, on 06/12/13 at 4:30 PM, revealed the liquid medication had not been transcribed to the Medication Administration Record (MAR), and should have been clarified with the physician. LPN #1 stated she would</p>		<ol style="list-style-type: none"> 1. Resident #5 physician was notified on 6-12-13 to obtain clarification order for Vancomycin form to be liquid. Order was obtained and resident was notified. No adverse effects noted related to receiving liquid form versus capsule. 2. 100% audit of all antibiotic orders, medication administration records, and medication carts were completed by the DON, ADON, and Unit Managers on 6-18-13 for the past 30 days to ensure that all antibiotic medication form was correct on the medication administration record and medication cart as it read on the physician order. No other medication form changes found. 3. An inservice was conducted by the Staff Development Coordinator on 6-20-13 for all licensed nursing staff related to obtaining a physician clarification order for any medication form changes after medication is received from the pharmacy. 		

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2013
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962		
(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 157	Continued From page 2 need to clarify the order with the physician, but had not talked with the pharmacy as to why the different form of medication was sent. Interview with the Pharmacist, on 06/13/13 at 9:00 AM, revealed the liquid medication Vancomycin was probably sent because of the cost. The pharmacist stated the capsules cost around \$2800.00 compared to \$260.00 in the liquid form. The pharmacist stated they usually do no clarify with the physician if equivalent, and would always send the liquid. Interview with the Director of Nursing (DON), on 06/13/13 at 3:30 PM, revealed that they normally would clarify the physician's orders with the physician, and should have called the pharmacy to clarify the change of the capsule form to liquid. The DON stated in the past they have had orders on the 30 day orders to ready "may change to generic or form"; however, Resident #5's orders did not reflect these orders.				
F 157			4. Audits will be completed by the DON, ADON, and Unit Managers daily, Monday through Friday x 4 weeks, then 5 weekly x 4 weeks, then 5 randomly x 3 months for all antibiotic medication orders to ensure antibiotic medication form is correct on the Medication Administration Record and the medication cart. The results of the audits will be reviewed at the monthly Performance Improvement (PI) Committee. Revisions will be made to the systems as indicated and audits will continue until committee determines compliance.		7-20-13
F 278	483.20(g) - (j) ASSESSMENT SS=D ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.				
F 278			1. The Staff Development Coordinator provided an inservice on 6-19-13 to the MDS Coordinator related to accurate coding of the resident assessment. Resident #15 MDS was corrected on 7-3-13 by the RN MDS Coordinator to reflect the resident's fall that occurred on 4-26-13. Resident #3 MDS was corrected on 7-3-13 by the RN MDS Coordinator to reflect the resident's restraint.		

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
---	--

(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 3

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 material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure accurate coding for the Minimum Data Set (MDS) Assessment for two (2) of twenty (20) sampled residents (Residents #3 and #15).

Resident #15's Quarterly MDS Assessment dated 06/06/13 was coded as the resident sustaining no falls; however, the resident sustained a fall on 04/26/13.

Resident #3's Quarterly MDS Assessment dated 05/26/13 was not coded for a restraint; however, the resident utilized a lap buddy which the facility had assessed as a restraint for the resident.

The findings include:

F 278 2. 100% audit of all MDS assessments completed in the last 30 days was completed on 6-24-13 by the DON, ADON, and MDS Coordinator to ensure accuracy of the resident's assessment.

3. An inservice was conducted by the Staff Development Coordinator on 6-20-13 for all licensed nursing staff completing MDSs related to accuracy of their portion of the assessment.

4. Audits will be completed by the DON, ADON, and Unit Manager daily Monday through Friday x 4 weeks, 2 x weekly for 4 weeks, and randomly 5 x a month x 3 months to ensure accuracy of the resident's assessment.

The results of the audits will be reviewed at the monthly Performance Improvement (PI) Committee. Revisions will be made to the systems as indicated and audits will continue until committee determines compliance.

7-20-13

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	
(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 4
Interview with the MDS Coordinator, on 06/13/13 at 5:40 PM, revealed there was no facility policy related to MDS coding, and the facility used the Resident Assessment Instrument (RAI) Manual as a reference.

F 278

1. Review of Resident #15's medical record revealed diagnoses which included Dementia, and Chronic Obstructive Pulmonary Disease. Review of the Quarterly MDS Assessment dated 06/06/13 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a thirteen (13). Further review revealed the facility assessed the resident as sustaining no falls in the past one (1) and two (2) months and as having no falls since admission/entry or the prior assessment.

Review of the Incident Follow Up and Recommendations Form, revealed on 04/29/13 Resident #15 went to sit down in the wheelchair and the wheelchair slid out from under the resident and the resident sustained a fall due to the wheelchair wheels not being locked. Further review revealed a therapy screen was recommended. As a follow up, on 05/03/13, the resident was educated on locking the wheelchair before attempting to rise, and staff was educated to give frequent cues to the resident to lock the wheelchair wheels before attempting to rise.

Interview, on 06/13/13 at 5:35 PM, with the MDS Coordinator and the Assistant MDS Coordinator revealed they attended the interdisciplinary meetings every morning and reviewed all falls and also reviewed all new Physician's Orders daily. Continued interview with the MDS Coordinator revealed she had completed the

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
---	--

(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 5

06/06/13 MDS Assessment for Resident #15 and must have missed the fall and miscoded the MDS related to the fall.

2. Record review revealed Resident #3 had a re-admission date of 10/22/12, with a diagnosis of Alzheimer. The resident was assessed for a lap buddy restraint when up in the wheelchair.

Observation of Resident #5, on 06/11/13 at 3:00 PM, revealed the resident sitting up in the wheelchair with a lap buddy restraint applied.

Review of Resident #5's Annual Comprehensive MDS Assessment, dated 02/25/13, under Section P (Physical Restraints) g. chair prevents rising, revealed Resident #5 was assessed to reflect the lap buddy restraint. However, review of the 05/25/13 quarterly MDS Assessment revealed the Restraint Section P was coded as 0, or no restraint. Review of the resident's current plan of care revealed the resident required a lap buddy to the wheelchair when up.

Interview with the MDS Coordinator, on 06/13/13 at 4:30 PM, revealed when assessments were completed, they followed the treatment records, which are reviewed by the seven (7) day look back period. The MDS Coordinator revealed Resident #5 had periods when he/she did not get up in the wheelchair, and may not have been up in the seven (7) day look back period to be coded. The treatment record information for the look back was not provided by the facility during the survey.

F 278

F 323 483.25(h) FREE OF ACCIDENT
SS=E HAZARDS/SUPERVISION/DEVICES

F 323

The facility must ensure that the resident

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
---	--

(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 323 Continued From page 6
environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interviews, and review of the facility's policy, it was determined the facility failed to ensure supervision to prevent accidents. One (1) of the West Wing medication rooms was observed to be open and un-supervised for over fifteen (15) minutes.

The findings include:

Review of the facility's policy titled, "LTC Facility's Pharmacy Services and Procedures Manual", Policy #5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, effective date 12/01/07, revision date 05/10/10, under General Storage Procedures 3.3 revealed the facility should ensure that all medications and biologicals, including treatment items, were securely stored in a locked cabinet/cart or locked medication room that was inaccessible by residents and visitors.

Observations conducted on the morning of 06/12/13 from 11:40 AM until 11:55 AM, revealed the medication room, directly across from the West Wing nursing station, was observed to be unlocked. There was no nurse or nursing

F 323:
1. The DON and ADON observed all medication rooms on 6-12-13 at 2:30 p.m. to ensure they were locked and/or supervised. All rooms were found locked and/or supervised. The DON and ADON completed a one-on-one education with LPN #3 related to the importance of keeping the medication cart and medication room locked and supervised at all times secondary to patient safety as well as providing safe and proper storage of drugs and biologicals.

2. 100% observation audit was completed on 6-18-13 by the DON and ADON of all medication rooms on different times to ensure they were supervised and/or locked to provide patient safety as well as providing safe and proper storage of drugs and biologicals.

3. An inservice was conducted on 6-20-13 by the Staff Development Coordinator (SDC) for all licensed staff related to the facility's policy on providing safe and proper storage of drugs and biologicals.

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
---	--

(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 CORRECTIDN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 7
personnel observed in the medication room or the nursing station.

Observation on 06/12/13 at 11:55 AM, revealed inside of the open medication room was one (1) medication cart which was not locked, one (1) refrigerator which was not locked, and one (1) wall cabinet which was unlocked. On top of the medication cart was an open unit dose container of Ferrous Sulfate 325 milligrams (mg); the refrigerator contained numerous vials of insulin and medicated suppositories; and the medication cabinet contained numerous boxes which contained unit dose vials of Albuterol and Xoponex. The total number of medications which were left open and un-supervised was well over one hundred (100) and too numerous to count. There was a total of eight (8) wandering residents present at the facility.

An interview conducted on 06/12/13 at 12:10 PM, with the medication nurse, Licensed Practical Nurse (LPN) #3, revealed she left the medication cart and door un-locked inadvertently when she heard one (1) of her residents calling for help. She stated she knew it was a mistake. LPN #3 stated she was aware of the importance and necessity of keeping the medication room and medication cart locked and supervised at all times.

An interview with the Director of Nursing (DON) and Assistant Director of Nursing, on 06/13/13 at 2:00 PM, revealed all of the nurses received training during orientation regarding the importance of keeping the medication cart and medication room locked and supervised at all times secondary to patient safety as well as

F 323
4. All medication rooms will be observed daily Monday through Friday x 4 weeks, then twice a week x 4 weeks, then 7 times randomly x 2 months to ensure they are kept supervised or locked to maintain safety and provide safe and proper of all drugs and biologicals.

The results of the audits will be reviewed at the monthly Performance Improvement (PI) Committee. Revisions will be made to the systems as indicated and audits will continue until committee determines compliance.

7-20-13

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	
(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 366 : Continued From page 9

Observation at the nurse's desk, on 06/11/13 at 12:35 PM, revealed staff called dietary and requested the chicken noodle soup; however, interview with the resident at 3:00 PM, revealed the resident did not receive the chicken soup.

Interview with the Unit Manager, on 06/11/13 at 3:30 PM, revealed she had checked with dietary to see why Resident #1 did not receive the soup; however, no one in the dietary knew why. The Unit Manager revealed the resident requested substitutes frequently, and many times would not eat healthy meals.

Interview with the Director of Nursing, on 06/13/13 at 3:35 PM, revealed any request for substitutes must come to the nurse's station, and should be called directly to the kitchen; some staff go directly to the kitchen and request the substitute and wait for it. The Unit Manager stated that staff keeps resident's informed of any substitutes available, as well as each posted at each nurse's station.

Interview with the Food Services Director, on 6/12/13 at 4:10 PM, revealed if staff called the kitchen with a request, then that dietary staff relays the message to the line staff. The Food Services Director stated that Resident #1 requested substitutes frequently, and she was not aware of the chicken noodle request; however, she also revealed requests were not written down when received. The Food Services Director stated they could remember any requests coming into the office.

F 431 483.60(b), (d), (e) DRUG RECORDS,
SS=E LABEL/STORE DRUGS & BIOLOGICALS

F 366 :

Nursing staff/Dietary Manager findings/audits will be reviewed monthly by the Performance Improvement (PI) Committee. Systems will be updated as indicated. Audits will continue until committee determines compliance.

7-20-13

F 431 :

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013	
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962		
(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 431 Continued From page 10

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 appropriate accessory and cautionary instructions, and the expiration date when applicable.

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.

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and review of

F 431

1. The DON and ADON observed all medication rooms on 6-12-13 at 2:30 p.m. to ensure they were locked and/or supervised. All rooms were found locked and/or supervised. The DON and ADON completed a one-on-one education with LPN #3 related to the importance of keeping the medication cart and medication room locked and supervised at all times secondary to patient safety as well as providing safe and proper storage of drugs and biologicals.

2. 100% observation audit was completed on 6-18-13 by the DON and ADON of all medication rooms on different times to ensure they were supervised and/or locked to provide patient safety as well as providing safe and proper storage of drugs and biologicals.

3. An inservice was conducted on 6-20-13 by the Staff Development Coordinator related to the facility's policy on providing safe and proper storage of drugs and biologicals.

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	
(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	<p>Continued From page 11</p> <p>the facility's policy, it was determined the facility failed to ensure storage of drugs and biologicals in locked compartments as per the facility's policy and procedures. One (1) of the West Wing medication rooms was observed to be unlocked which contained an unlocked medication cart, unlocked medication refrigerator and an unlocked medication cabinet.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "LTC Facility's Pharmacy Services and Procedures Manual", Policy #5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, effective date 12/01/07, revision date 05/10/10, under General Storage Procedures 3.3 revealed the facility should ensure that all medications and biologicals, including treatment items, were securely stored in a locked cabinet/cart or locked medication room that was inaccessible by residents and visitors.</p> <p>Observations, on the morning of 06/12/13 from 11:40 AM until 11:55 AM, revealed the medication room, directly across from the West Wing nursing station, was observed to be unlocked. Observation revealed no nurse or nursing personnel in the medication room or the nursing station.</p> <p>Observation, on 06/12/13 at 11:55 AM, revealed inside of the unlocked medication room was one (1) medication cart which was not locked, one (1) refrigerator which was not locked, and one (1) wall cabinet which was unlocked. On top of the medication cart was an open unit dose container of Ferrous Sulfate 325 milligrams (mg); the</p>	F 431	<p>4. All medication rooms will be observed daily Monday through Friday x 4 weeks, then twice a week x 4 weeks, then randomly x 2 months to ensure they are kept supervised or locked to maintain safety and provide safe and proper of all drugs and biologicals.</p> <p>The results of the audits will be reviewed at the monthly Performance Improvement (PI) Committee. Revisions will be made to the systems as indicated and audits will continue until committee determines compliance.</p> <p>7-20-13</p>

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2013
NAME OF PRDVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	
(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 12

refrigerator contained numerous vials of insulin and medicated suppositories; and the medication cabinet contained numerous boxes which contained unit dose vials of Albuterol and Xoponex. The total number of medications which were left open and un-supervised was well over one hundred (100) and too numerous to count.

Interview on, 06/12/13 at 12:10 PM, with the medication nurse, Licensed Practical Nurse (LPN) #3, revealed she left the medication cart and door un-locked inadvertently when she heard one (1) of her residents calling for help. She stated she knew it was a mistake. LPN #3 stated she was aware of the importance and necessity of keeping the medication room and medication cart locked at all times.

Interview, on 06/13/13 at 2:00 PM, with the Director of Nursing (DON) and Assistant Director of Nursing revealed all of the nurses received training during orientation regarding the importance of keeping the medication cart and medication room locked and supervised at all times secondary to patient safety as well as providing safe and proper storage of drugs and biological. The DON stated it was her expectation that the nursing personnel kept the medication carts and medication rooms locked at all times when not in use as per the facility's policy.

F 431

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

PRINTED: 06/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2013
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(D) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)
BUILDING: 01
PLAN APPROVAL: 1976
SURVEY UNDER: 2000 Existing
FACILITY TYPE: SNF/NF
TYPE OF STRUCTURE: One story, Type V(000)
SMOKE COMPARTMENTS: Five
FIRE ALARM: Complete automatic fire alarm system
SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system
GENERATOR: Type II diesel generator
A life safety code survey was initiated and concluded on 06/11/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.



K-000

Disclaimer for Plan of Correction

Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Kentucky Medical Investors Ltd., d/b/a Laurel Creek Health Care Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Kentucky Medical Investors Ltd., d/b/a Laurel Creek Health Care Center files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicaid/Medicare Program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction would not be taken as establishing any standard of care, and the facility submits that the actions by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal, or equitable, in administrative, civil or criminal proceeding.

K 046 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 046

Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.

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

[Signature]

TITLE

[Signature]

(X6) DATE

07-05-13

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: 06/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2013
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	
(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)

K 046 Continued From page 1

K 046

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain emergency lighting at an exterior exit according to National Fire Prevention Association (NFPA) standards. This deficient practice affected one (1) of five (5) smoke compartments, staff and approximately fifteen (15) residents. The facility has the capacity for 106 beds with a census of 96 on the day of the survey.

The findings include:

During the Life Safety Code tour, on 06/11/13 at 09:50 AM, with the Director of Maintenance (DOM), an exit located on the east wing of the facility was observed not to have emergency lighting at the exterior of the exit that would illuminate the path of travel to the public way.

An interview with the DOM, on 06/11/13 at 09:50 AM, revealed he was not aware the available lighting was not sufficient enough to be able to provide enough emergency lighting to the public way.

The findings were revealed to the Administrator on exit.

Reference: NFPA 101 2000 edition
19.2.9.1

Emergency lighting shall be provided in accordance with Section 7.9.

7.9.1.1*

Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9

1. An exit located on the East Wing of the facility was observed to not have emergency lighting at the exterior of the exit that would illuminate the path of travel to the public way.

2. There is no lack of lighting at the four (4) other smoke compartments.

3. An inservice was conducted on 6-14/19-2013 by the Maintenance Director for all staff to inform them that emergency lighting would be installed on East Wing at the exterior of the Exit by 7-20-13.

4. Audits will be conducted by the Department Managers 1 x a day Monday through Friday for 4 weeks, then 3 x a week for 4 weeks, then 1 x a week for 2 months to ensure lighting at the exterior of the exit.

The results of the audits will be reviewed at the monthly Performance Improvement (PI) Committee. Revisions will be made to the systems as indicated and audits will continue until committee determines compliance.

7-20-13

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

PRINTED: 06/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
---	--

(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 046	<p>Continued From page 2</p> <p>for the following:</p> <p>(1) Buildings or structures where required in Chapters 11 through 42</p> <p>For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.</p> <p>7.9.2.2*</p> <p>The emergency lighting system shall be arranged to provide the required illumination automatically in the event of any of the following:</p> <p>(1) Interruption of normal lighting such as any failure of a public utility or other outside electrical power supply</p> <p>(2) Opening of a circuit breaker or fuse</p> <p>(3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities</p> <p>7.8.1.1*</p> <p>Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.4*</p> <p>Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p>	K 046
-------	--	-------

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

PRINTED: 06/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
---	--

(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 046 Continued From page 3
A.7.8.1.4
An example of the failure of any single lighting unit is the burning out of an electric bulb.

K 072 NFPA 101 LIFE SAFETY CODE STANDARD
SS-F
Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.
7.1.10

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to maintain exits according to NFPA standards. This deficient practice affected four (4) of five (5) smoke compartments, staff and approximately eighty (80) residents. The facility has the capacity for 106 beds with a census of 96 on the day of the survey.

The findings include:

During the Life Safety Code tour, on 06/11/13, at 9:50 AM, with the Director of Maintenance (DOM) an exit door located in the east wing of the facility was observed to have signage hidden by a window curtain. The signage indicated on how to exit the building in case of an emergency.

An interview with the DOM, on 06/11/13 at 9:50 AM, revealed he did not notice the curtains were hiding the signage. During the survey three (3) other exit doors were observed to have curtains hiding the signage.

K 046

K 072

1. Once notified by the surveyor the facility was made aware that East Wing door signage was hidden by a window curtain, the curtain was removed immediately on 6-11-13.
2. Audits were conducted on 4 exit doors and 3 of the 4 doors had curtains that covered the signage. Curtains were removed immediately. No adverse effects noted on 6-11-13.
3. The Executive Director conducted an inservice on 6-14/18-2013 with all associates to inform them that the signage had been removed from the doors and placed on the wall beside the doors.
4. Housekeeping staff will audit doors 1 time a day Monday through Friday for 2 weeks, then 2 x a week Monday through Friday for 1 week, then 1 x a month for 4 months to ensure signage is located beside the door.

The results of the audits will be reviewed at the monthly Performance Improvement (PI) Committee. Revisions will be made to the systems as indicated and audits will continue until committee determines compliance.

7-20-13

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

PRINTED: 06/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
---	--

(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 072 Continued From page 4

K 072

The findings were revealed to the Administrator on exit.

Reference: NFPA 101 2000 edition
19.2.10.1

Means of egress shall have signs in accordance with Section 7.10.

7.10.1.7* Visibility.

Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted.