

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

PRINTED: 01/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/28/2012
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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<p>F 000 INITIAL COMMENTS</p> <p>A recertification survey was conducted on 12/26/12-12/28/12 and a Life Safety Code survey was conducted on 12/27/12 with deficiencies cited at the highest scope and severity at an "F". The facility had the opportunity to correct the deficiencies before imposition of remedies would be recommended.</p> <p>In addition, KY19552 was investigated concurrent with the standard survey and was found to be unsubstantiated.</p> <p>F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p>	<p>F 000 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>F 156 F156 Completion Date 1/25/2013 SS=B Notice of Rights Rules, Services, Charges --- Regarding Medicare Provider Non-Coverage Letters</p> <p>The Social Service Director issued these Medicare Non Coverage Letters for Resident # 14, and Unsampled Resident A, along with an explanation letter of why we were sending them to correct our non-compliance with this regulation by 1/22/2013.</p> <p>The Social Service Director did not issue the Medicare Non Coverage Letter for Resident #15 because this resident had expired, after discharge from the facility.</p> <p>The Social Service Director went back to August 6, 2012, (employment start date of the Social Service Director) to identify all Medicare residents that had been discharged</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>* [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/12/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156 Continued From page 1

inform each resident when changes are made to the items and services specified in paragraphs (5) (1)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

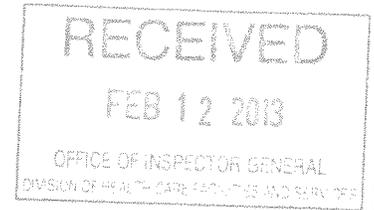
The facility must furnish a written description of legal rights which includes:

- A description of the manner of protecting personal funds, under paragraph (c) of this section;
- A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.
- A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the

F 156 from the facility. There were a total of 18 residents identified; however 5 of these had expired after discharge from the facility. All of these identified (minus the 5 who had expired) were sent a Medicare Non Coverage Letter, along with an explanation letter of why we were sending them to correct our non-compliance with this regulation by 1/22/2013.

Administrator provided education and training to the Social Service Director, Business Office Manager, and the Director of Marketing/Admissions regarding the regulations of when to provide Medicare Non Coverage Letters to all Medicare residents when skilled services are ending but resident remaining at facility under a different payor and when resident discharging from the facility due to skilled services ending or because of a self-determined discharge. This was completed on 12/30/2012.

During this survey, the surveyors acknowledged in the statement of deficiency that the facility was giving appropriate notice of rights, rules, services, and charges to residents. The only issue with this regulation was with not all Medicare residents being discharged from the facility due to skilled services ending and due to a self-determined discharge were being issued the Medicare Non coverage Letter according to regulations. This plan of correction addresses the issues and with the steps



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F 156 Continued From page 2
facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

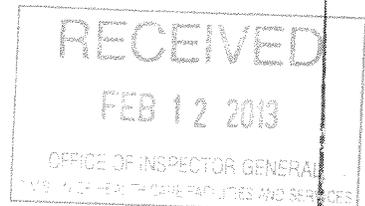
The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on closed record review and interview it was determined the facility failed to ensure Medicare A residents were issued a "Notice of Medicare Provider Non-coverage" letter upon termination of all Medicare Part A services for three (3) of three (3) closed records reviewed. The facility failed to issued a non-coverage letter,

F 156 taken, the facility should be in full compliance with this regulation as of 1/25/2013.

Social Service Director will maintain a binder where copies of all Medicare Non-Coverage Letters to resident are kept, effective for 12/28/2012. Social Service Director will request a list of discharges by payor each week for 4 weeks, then monthly for 11 months from the Business Office Manager and will compare the Medicare Non-Coverage Letters issued to the Medicare discharges on the list from the Business Office to ensure that all Medicare residents were issued their Medicare Non-Coverage Letters. Social Service Director must alert the Administrator immediately of any missed and untimely letters. This auditing will start for the week of 12/30/2012 and will continue for 4 weeks, then monthly for 11 months.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at



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F 156 Continued From page 3
with information on beneficiary appeal rights for those residents that were discharged from the facility after Medicare Part A services were terminated. The facility only provided that information to those residents who continued to reside in the facility after Medicare Part A services was terminated. (Residents #14, #15 and Unsampled Resident A)

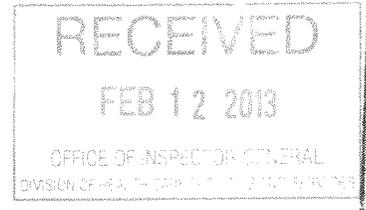
The findings include:

The facility did not provided a specific policy related to Non-coverage letters. The corporate representative indicated the facility followed the federal regulation guidelines for Medicare beneficiaries.

Review of the facility's admission/financial agreement revealed the facility provided information on how the resident can apply for benefits under Medicare and Medicaid. A copy of a blank Notice of Medicare Non-coverage letter was included in the admission packet and provided to the resident or responsible party during the admission process.

1. A closed record review of Resident #14's clinical record revealed the facility admitted the resident on 11/20/12 for skilled services under Medicare Part A. The record revealed the resident was discharged to home on 12/04/12 with skilled days remaining. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.
2. A closed record review of Resident #15's clinical record revealed the facility admitted the

F 156 least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.



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F 205 Continued From page 5
SS=B POLICY BEFORE/UPON TRANSFR

Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's bed-hold policy, it was determined the facility failed to provide written information regarding the bed-hold process for three (3) of fifteen (15) sampled residents that were transferred to the hospital (Resident #11, #12 and #13). Residents #11, #12 and #13 were transferred from the nursing facility to the hospital without written notice of bed-hold.

The findings include:

Review of the facility's policy titled, Bed-Hold,

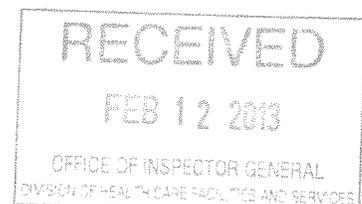
F 205 SS=B
Notice of Bed Hold

Business Office Manager issued Bed Hold Letters for Resident #11, Resident #12, and Resident # 13, along with an explanation letter of why we were sending them to correct our non-compliance with this regulation by 1/18/2013.

Business Office Manager researched back to 8/1/2012 through 12/28/2012 to determine all the residents that had been transferred out to the hospital to identify other potential residents that were affected by this deficient practice. There were a total of 39 other residents affected. Business Office Manager issued Bed Hold Letters to all of these residents, along with an explanation letter of why we were sending them now to correct our non-compliance with this regulation. This was completed by 1/22/2013.

Director of Education & Training re-educated and trained all licensed nursing staff regarding the need to review and initiate the facility Bed Hold Policy. This was completed by 1/21/2013.

The Administrator re-educated and trained the Business Office Manager of the facility Bed Hold Policy and her responsible with this process. This was completed on 12/28/2012.



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F 205 Continued From page 6
effective date July 1, 2012, which is located in the resident's admission packet, revealed the bed-hold policy follows the required law requirements. When the facility determines that a transfer of a resident is required; the facility would abide by all applicable requirements, including provision of adequate notice to the resident/legal representative regarding the bed-hold information.

Review of a blank copy of the facility's bed-hold form revealed all residents or responsible party may elect to have a bed-hold while absent from the facility. Bed holds for days of absence in excess of the state's bed hold limit (14 days per year) are considered non covered services.

1. Review of the clinical record for Resident #11 revealed the facility admitted the resident on 08/29/12 with diagnoses of: Hypertension, Anemia and Dementia. The facility completed a Minimum Data Set (MDS) assessment on 09/12/12 which revealed the resident was not cognitively intact. The facility transferred the resident to the hospital on 08/31/12 and the resident returned on 09/05/12. The facility was unable to provide documented evidence the resident or responsible party received written information regarding bed-hold notice prior to being sent to the hospital.

2. Review of the clinical record for Resident #12 revealed the facility admitted the resident on 10/31/12 with diagnoses of Confusion and Hypertension. The facility completed an Initial MDS assessment on 11/06/12 which revealed the resident was not cognitively intact. The facility sent the resident to the hospital on 12/08/12.

F 205 Business Office Manager will run a weekly report for 4 weeks, then monthly for 11 months of all residents that have been transferred to the hospital to ensure that a Bed Hold Letter was initiated and sent to the resident and/or responsible party. Business Office Manager must alert the Administrator immediately of any missed and untimely letters. This auditing will start for the week of 12/30/2012 and will continue for 4 weeks, then monthly for 11 months.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.



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F 205 : Continued From page 7
The facility was unable to provide documentation that the resident or responsible party received written information of bed-hold notice prior to being sent to the hospital.

F 205 :

3. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 03/01/12 with diagnoses of Lung Cancer, Chronic Obstructive Pulmonary Disease (COPD), and Bone Metastasis. The facility completed a quarterly MDS assessment on 11/03/12 that revealed the resident was cognitively intact. The facility sent the resident to the hospital on 11/03/12 and 11/29/12. The facility was unable to provide documentation that the resident or responsible party received written bed-hold information prior to being sent to the hospital.

Interview with the Business Office Manager, on 12/28/12 at 10:45 AM, revealed the facility had changed ownership and bed-hold notices were no longer given to the resident or family member. She further stated the facility had no documented copy of the bed-hold notice.

Interview with Resident #13, on 12/28/12 at 11:00 AM, stated no written information regarding bed-hold notice had been given prior to being transferred to the hospital.

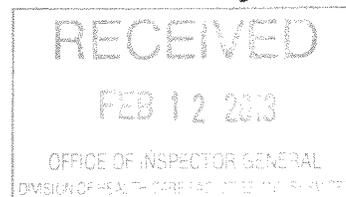
Interview with the Regional Nurse Consultant, on 12/28/12 at 11:20 AM, revealed the facility provided information regarding bed-hold notice during the admission process; however, the facility had not provided written notice of Bed-hold to residents that were transferred to the hospital since August 2012.

F280

Completion Date 1/25/2013

F 280 : 483.20(d)(3), 483.10(k)(2) RIGHT TO

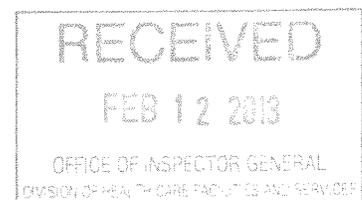
F 280



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F 280 SS=D	<p>Continued From page 8</p> <p>PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's Care Plan Policy, it was determined the facility failed to revise/update the care plan for two (2) of fifteen (15) sampled residents. Resident #4 and #12. Resident #4 was aphasic; however, the care plan noted the resident would verbalize pain relief, thoughts and feelings. Resident #12 had a care plan that addressed an infection without indicating what type of infection or what the plan was for the infection.</p>	F 280	<p>SS=D</p> <p>Right To Participate Planning Care --- Regarding Revised Care Plans</p> <p>Resident #4 care plan was revised to state that the resident was aphasic on 12/27/2012 by the interdisciplinary team.</p> <p>Resident #4 care plan for comfort was revised and the goal of resident voicing relief from pain intervention was removed on 12/28/2012 by the interdisciplinary team.</p> <p>Resident #4 elopement care plan was revised and the goal that the resident would verbalize thought and feelings appropriately and the intervention of the resident verbalizing thoughts and feelings was removed on 12/28/2012 by the interdisciplinary team.</p> <p>Resident #4 activity care plan was revised and the preference of talking on the phone was removed on 12/28/2012 by the interdisciplinary team.</p> <p>Resident #12 actual infection care plan was removed from the resident's record since the resident did not have an actual infection on 12/28/2012 by the interdisciplinary team.</p> <p>100% audit was completed by the DON, ADON, and ETD to determine other residents that had the potential to be affected by this deficient practice. This audit was completed by 1/22/2013. There were a total</p>



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F 280 Continued From page 9

The findings include:

Review of the facility's Care Plan Policy, undated, revealed the care plan was based on a thorough assessment of the resident. It also stated each resident's care plan would incorporate identified problem areas.

Review of the clinical record for Resident #4 revealed the facility admitted the resident on 07/01/12 with diagnoses of Pneumonia, Late effects of Cardiovascular Disease-Aphasia and Diabetes. The care plan for Resident #4 listed comfort as a problem with the goal of having Resident #4 voice relief from pain interventions within a half hour of receiving medication. The care plan also addressed the problem of a risk for elopement related to the cognitive status of the resident. The goal was the resident would verbalize thoughts and feelings appropriately and included the intervention of allowing the resident to again verbalize thoughts and feelings. An intervention was listed under the potential for side effects related to psychotropic drug use was to monitor the resident for disorganized speech. The Activity Pursuit Plan of Care listed an activity preference of Resident #4 as talking on the phone. Resident #4 was aphasic, which the care plan did address in the potential problem for alteration in communication.

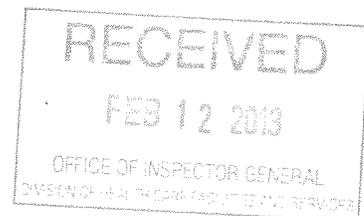
Review of the clinical record for Resident #12 revealed the facility admitted the resident on 10/31/12 with diagnoses of Confusion and Hypertension. The care plan for Resident #12 noted an actual infection, but did not indicate what type of infection was present, and there

F 280 of 4 other residents identified. All other identified residents care plans needing revisions were revised as appropriate by 1/24/2013 by the interdisciplinary team.

Director of Nursing will re-educate and train Social Services, Activities, Dietary, MDS Coordinator, Assistant Director of Nursing, Director of Education & Training, Unit Manager, and Licensed Nursing Staff on care planning requirements as follows:

1) comprehensive care plans must be developed within 7 days after the completion of the comprehensive assessment; 2) care plans are to be prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs; and if practicable, the participation of the resident, the family, or legal representative; 3) care plans must be periodically reviewed and revised by a team of qualified persons after each assessment; and 4) revisions to care plans have to be appropriate to resident cognitive level, ADL ability, communication ability, resident preferences, and disease processes. This education was completed by 1/22/2013.

Nursing staff competency will be determined by auditing care plans to ensure changes were made, if appropriate, and if care plans meet resident individual needs. A post test was given immediately after re-



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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 280 Continued From page 10
were no goals or any interventions marked. The start date on the care plan was 12/11/12 and an end date was listed as 03/13 for the infection to resolve.

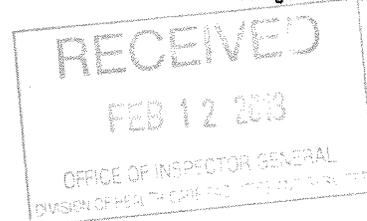
Interview, on 12/28/12 at 4:50 PM, with the Assistant Director of Nursing (ADON) revealed the computer generated care plans were printed, then gone through to make sure everything the resident needed was included. She revealed the care plan of each resident was reviewed at a minimum of quarterly by the Interdisciplinary Team (IDT). She stated the IDT ensured that the care plans were accurate, and each discipline had their own care plan. The ADON revealed the care plan for Resident #4 did not reflect the medical picture of the resident and the actual infection on the care plan of Resident #12 should not have been there.

Interview, on 12/28/12 at 5:07 PM, with Minimum Data Set (MDS) Registered Nurse (RN) revealed the care plans were generated by a computer. Care plans were picked from the computer choices and then individualized by the staff. She revealed nursing produced the first care plan for a resident and then she checked the care plan for omissions, and adds to the care plan. She revealed care plans were reviewed quarterly unless an event required addressing the care plan sooner. She stated the care plans do not reflect an interdisciplinary approach to care plans. In addition, she revealed the current care plan process was not an accurate representation of the care the resident received. For Resident #4, she revealed the care plan was not realistic for the resident. The care plan had the resident speaking and Resident #4 was aphasic. Related

F 280 education & training to also verify all nursing staffs competency. This was completed by 1/24/2013.

Director of Nursing, Director of Education & Training and/or Assistant Director of Nursing will audit 5 residents care plans each week for 12 weeks and then will audit 5 resident care plans monthly for 9 months to ensure that care plan revisions are appropriate for the resident as outlined above regarding the staff education. This auditing will start the week of 1/27/2013.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and



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F 280 Continued From page 11 to Resident #12, she revealed the care plan was not accurate for an infection.

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=E 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 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.

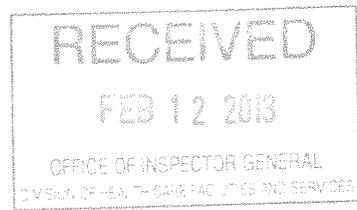
F 280 recommend any further interventions, as deemed appropriate.

F 431

F431 Completion Date 1/25/2013
SS=E
Drug Records, Label/Store Drugs & Biologicals

The Silver Alginate Antimicrobial 4x4 dressing and the one tube of Nature-Shield Cream that had expired for Unsampled Resident B was removed from the medication cart by the Assistant Director of Nursing on 12/27/2013 and discarded according to policy. In addition, the Heritage Hall Treatment Cart that contained one Dura Fiber absorbent 4x4 dressing and one 2x2 barrier dressing was removed from this medication cart by the RN Unit Manager on 12/27/2012 and discarded according to policy.

In addition, the Assistant Director of Nursing and the RN Unit Manager completed a one time audit of all medication carts to identify any medications that were not labeled or had expired on 1/22/2013. No issues were noted. The Assistant Director of Nursing and the RN Unit Manager completed a one time audit of all narcotic medications to make sure the count was correct and that all medications were labeled correctly on 1/22/2013. No issues were



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F 431 Continued From page 12

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to store medical supplies and medications in accordance with accepted professional principles and in agreement with their policy for delivery and storage of medications. Two (2) of three (3) treatment carts on two (2) halls contained expired wound treatment supplies and a tube of barrier cream with an expired date for un-sampled Resident B.

The findings include:

Review of the facility's policy titled Delivery and Storage of Medications and Supplies, dated as revised August 15, 2008, stated expiration dates for medications will be checked.

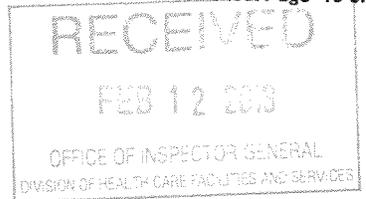
Observation, on 12/27/12 at 3:00 PM, on the Horseshoe Treatment Cart revealed one (1) Silver Alginate antimicrobial 4 x 4 dressing (expiration 08/2012), and one (1) tube of Nutra-Shield Cream (expiration 11/2012) for Unsampled Resident B. In addition, the Heritage Hall Treatment Cart contained one (1) Dura Fiber absorbent 4 x 4 dressing (expiration 09/2011), and one (1) 2 x 2 barrier dressing (expiration 07/2012).

Interview, on 12/28/12 at 10:25 AM, with Registered Nurse (RN) #1 revealed nurses who are assigned to treatment carts should check the contents daily. Expired supplies and medications should be removed and/or any medications that have been discontinued. In addition, nurses

F 431 noted. The Assistant Director of Nursing and the RN Unit Manager completed a one time only audit of all medication kept in refrigerators to make sure all temperatures were correct and that all multi-dose medications were properly labeled on 1/22/2013. No issues were noted.

All three of the facility treatment carts and the medication carts and supply/med rooms were check for expired items by the Unit Manager and the Assistant Director of Nursing on 12/27/2012. Neither other residents nor treatment or medication carts or supply/medication rooms were identified having any expired items.

Director of Education & Training will re-educate and train the licensed nursing staff regarding the importance and need to check treatment carts to ensure that all supply items that have expired are removed and discarded according to policy. In addition, this education and training will include instructing the licensed nursing staff that when a resident's treatment changes or is discontinued that the treatment supply items no longer needed are removed from the treatment cart immediately; explaining about proper storage of drugs and Biologicals, temperatures for storage of drugs and Biologicals, narcotic storage and count, dating and labeling multi-dose vials, discarding medications along with checking dates prior to administration. This was completed on 1/23/2013. Nursing staff



F431 --- Continued From Page 14

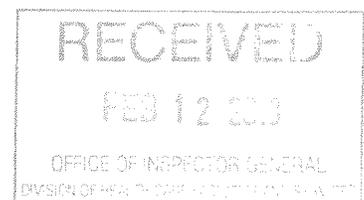
The Director of Education & Training will ensure that when completing orientation for newly employee licensed nursing staff that they are aware of responsibilities outlined in this regulation as part of their orientation training and post testing competency. This is effective starting 12/27/2012.

The Director of Nursing, Assistant Director of Nursing, RN Unit Manager and/or the Director of Education & Training will be assigned responsibility for monitoring the three treatment carts, medication carts, supply/medication rooms at the facility to ensure that there are no expired items left in carts; to ensure that drugs and Biologicals are dated, and initialed; to ensure that narcotic medications are counted and labeled correctly, and to ensure that temperatures for storage of drugs and Biologicals are maintained. This monitoring will be completed weekly and will be documented for completion for the next 12 weeks and then monthly for next 9 months. The weekly monitoring will start for the week of 1/20/2013.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and

F431 --- Continued on Page 14B

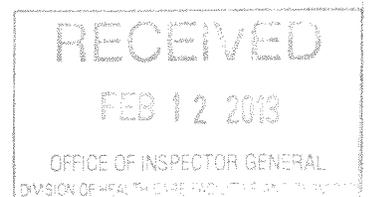
Page 14A



F431 --- Continued From Page 14A

monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

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F 431 Continued From page 13
should check the expiration dates of creams, medications, and supplies before each scheduled treatment.

Interview, on 12/28/12 at 3:20 PM, with the Director of Nurses (DON) revealed nurses should check treatment cart supplies and medications at least weekly, and remove items with expired dates. In addition, medications and supplies should be removed from the carts as soon as they have been discontinued. The DON stated she expected the Unit Manager (UM) to assure this task was completed. The DON stated the potential problem with not monitoring this activity would be using medications and supplies that would not be as effective as in-date products.

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

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

F 431 competency will be determined by the outlined monitoring and auditing to ensure changes were made in practice with meeting resident needs, as educated above. A post-test was given immediately after re-education & training to also verify all nursing staffs competency. This was completed by 1/24/2013.

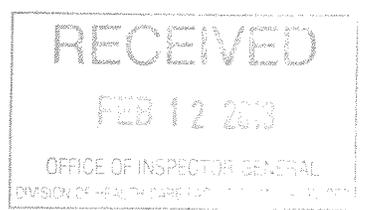
F431 --- Continued on Page 14A

F 441 F441 Completion Date 1/25/2013 SS=E Infection Control, Prevent Spread, Linens

Resident #5 --- nebulizer equipment was cleaned and new tubing and mask was issued to the resident on 12/26/2012 by nursing staff. Then when it was discovered that nebulizer mask and tubing was touching a plant, it was again thrown away and replaced on 12/28/2012 by nursing staff.

Resident in Room 21-1 --- nebulizer mask and tubing was thrown away, new tubing issued, and equipment was cleaned on 12/26/2012 by nursing staff.

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F 441 Continued From page 14
prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's Infection Control Policies and Practices, Revised August 2011, it was determined the facility failed to implement their infection control program as it pertained to the storage of nebulizer masks, nasal cannulas and urinals. One (1) of fifteen (1) sampled residents, Resident #5, had a nebulizer face mask sitting in a window sill uncovered. In addition, in five (5) other resident rooms, respiratory equipment and urinals were not properly stored.

The findings include:

Review of the Infection Control Policies and Practices, Revised August 2011, revealed an objective was to prevent and control infections in the facility and to maintain a sanitary

F 441 F441 --- Continued From Page 14
Resident in Room 23-1 --- urinal was removed from the over bed table, thrown away and new urinal was issued to resident on 12/26/2012 by nursing staff.

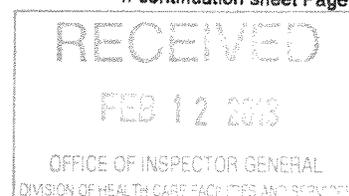
Resident in Room 23-2 --- urinal was removed from the walker, thrown away, and a new urinal was issued to resident, and the walker was cleaned on 12/27/2012 by nursing staff. Resident nebulizer mask and tubing was thrown away, new mask and tubing was issued, and equipment was cleaned on 12/26/2012 by nursing staff.

Resident in Room 23-A --- urinals was removed from the walker, thrown away, and the walker cleaned on 12/27/2012 by nursing staff.

Resident in Room 27-A --- urinal was removed from the over bed table, thrown away, new urinal issued, and over bed table cleaned on 12/28/2012 by nursing staff. Also the resident's nasal cannula was thrown away and replaced with new tubing on 12/28/2012 by nursing staff.

Resident in Room 32-A --- nasal cannula and oxygen tubing was thrown away and replaced on 12/28/2012 by nursing staff.

All other residents that use urinals were identified and there urinals were thrown away and replaced with resident names on



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F 441 Continued From page 15
environment. In addition, the policy revealed all staff would be trained on infection control policies and practices.

The facility did not provide a policy for oxygen tubing with nasal cannula or nebulizer face masks.

Observation, on 12/26/12 during the tour of the facility which began at 8:30 AM, revealed an uncovered nebulizer mask in the window in the room of Resident #5. Droplets were observed in the reservoir of the mask. In addition, in Room 21-1 a nebulizer face mask and tubing was attached to the machine uncovered hanging between the resident's headboard and mattress. Room 23-1 was found to have a urinal on an overbed table and Room 23-2 had a urinal on the top part of a walker and a nebulizer face mask out, uncovered sitting in the open machine.

Observation, on 12/27/12 at 12:20 PM, revealed a urinal on a walker in Room 23-A, in close proximity to the lunch tray on the overbed table.

Observation, on 12/28/12 at 9:15 AM, in Room 27-A was a urinal with a yellow liquid in it sitting on the overbed table.

Observation, on 12/28/12 at 11:00 AM and 2:30 PM, revealed a nebulizer mask and tubing uncovered, and touching a plant in the window of the room of Resident #5.

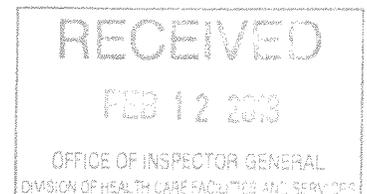
Observation, on 12/28/12 at 2:30 PM, in Room 27-A was a nasal cannula draped over the bed side table, uncovered, and the oxygen tubing on the floor. Also, in Room 32-A was a nasal

F 441 the urinal, placed in plastic bags, and placed within the residents' reach but away from the over bed tables and walkers on 12/28/2012 by nursing staff.

All other residents that use Nebulizer masks and tubing were identified and there masks and tubing was thrown away and replaced with new in plastic bags with dates, and equipment was cleaned on 12/27/2012 by nursing staff.

All other residents that use oxygen tubing, had their tubing replaced and dated with plastic bags, and equipment was cleaned on 12/27/2012 by nursing staff.

Director of Education & Training will re-educate and train the nursing staff regarding the importance and need to replace oxygen tubing in plastic bags when not in use; that nebulizer masks are to be cleaned when the nebulizer treatment is completed and stored in plastic bags; that all Nebulizer and oxygen tubing is to be replaced at least weekly, on Sundays, by 3rd shift nursing staff; urinals are to be changed once week, residents name placed on them, and placed in plastic bags when not in use, and placed within resident reach; urinals are not to be placed on over bed tables and if a resident places a urinal on an over bed table that it is cleaned before anything else is placed on the over bed table; and that no oxygen or Nebulizer equipment is to be sitting near plants by 1/21/2013.



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		(X5) COMPLETION DATE	

F 441 Continued From page 16
cannula and oxygen tubing on the seat of a wheelchair uncovered.

Interview, on 12/28/12 at 2:40 PM, with Licensed Practical Nurse (LPN) #2 revealed oxygen equipment was to be stored in a plastic bag with the name and room number of the resident on it. She revealed she had been in-serviced on the storage of oxygen equipment and infection control. She gave the reason for proper storage of the equipment was for cleanliness, to keep items from getting dirty. She said all staff monitor the resident rooms for proper storage. She revealed the consequence for improper storage was contamination, which could lead to infection.

Interview, on 12/28/12 at 2:40 PM, with LPN #3 revealed oxygen cannulas and nebulizer face masks were stored in bags in the resident's room when not in use. She gave the reason for this to be infection control, to keep the equipment clean. She revealed the failure to properly store the equipment could cause the resident to come down with an infection. For an ill resident, she revealed, you do not want to add to their illness by exposure to dirty equipment. She revealed all the staff monitored the storage of equipment.

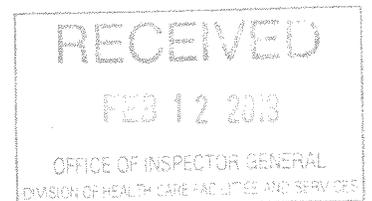
Interview, on 12/28/12 at 3:15 PM, with LPN #1 revealed oxygen equipment was stored in a bag with the resident's name and the date. She revealed this was done to prevent contamination, cross contamination and germs. She stated urinals on overbed tables was not sanitary or appealing, especially at meal time. She revealed all staff were responsible for monitoring equipment.

F 441

In addition, the Director of Education & Training re-educated all nursing staff on the following: 1) Process of handling, storing, and transporting linens to prevent spread of infection; 2) Requirement of Handwashing after each direct resident contact; 3) prohibiting employees with communicable disease or infected skin lesions from direct contact with residents or food; 4) When a resident needs isolation to prevent the spread of infection, the facility will isolate the resident; and 5) Explaining the purpose of the infection control program --- to investigate, control, and prevent infections; to isolate residents as determined appropriate; and to maintain a record of incidents and corrective actions related to infections. This education was completed by 1/23/2013. Also, a post test was given immediately after re-education & training to verify nursing staffs competency. This was completed by 1/24/2013.

The Director of Education & Training will ensure that when completing orientation for newly employee nursing staff, that they are aware of responsibilities outlined above as part of their orientation training and post-test competency. This is effective starting 12/27/2012.

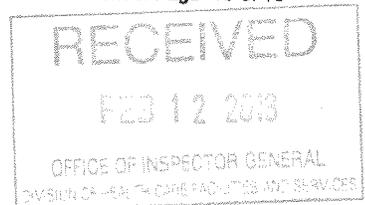
The Director of Nursing, Assistant Director of Nursing, RN Unit Manager, and Director of Education & Training will conduct weekly monitoring of urinals to ensure they



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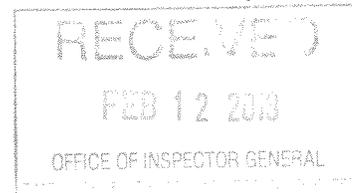
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/28/2012
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 441	<p>Continued From page 17</p> <p>Interview, on 12/28/12 at 3:18 PM, with Certified Nursing Assistant (CNA) #1 revealed she had not been in-serviced on the storage of oxygen equipment. She revealed the urinals should not be placed on the overbed table because it was not sanitary and the resident's eat there. She revealed everybody monitored the urinals.</p> <p>Interview, on 12/28/12 at 3:20 PM, with Registered Nurse (RN) #1 revealed oxygen equipment was to be dated and stored in a bag. She had been in-serviced and gave the reason for proper storage so the resident would not catch more bacteria. She stated that urinals, when not in use, should be stored in the resident's bathroom.</p> <p>Interview, on 12/28/12 at 3:30 PM, with the Education/Training Director revealed that oxygen equipment was stored in a bag that was changed weekly. The equipment was not to be set on a bed or stretched across a bed. It was to be cleaned after use and placed in the bag. She continued that she in-serviced licensed staff on the equipment. She revealed you would spread germs if you did not clean the equipment and properly store it. She revealed the nurse assigned to the resident with oxygen equipment was responsible to monitor the equipment. She did not have knowledge of any infection control rounds. Continued interview revealed urinals were to be clean and dated and within the reach of the resident. She stated the urinals do not belong on an overbed table, on the floor or in the window. She stated the CNA was responsible for the urinals. She stated all staff share in the roll of educating the resident on the proper storage of the urinal, not just one staff member.</p>	F 441	<p>are changed weekly and not placed on bed tables and walkers, placed in plastic bags when not in use, but in reach of the residents; that oxygen and Nebulizer tubing is changed weekly according to the schedule; that oxygen and nebulizer tubing is stored in plastic bags; and that Nebulizer equipment and oxygen tubing is not sitting near plants. Also, monitoring will include ensuring that staff are handling, storing, and transporting linens correctly, that handwashing is taking place after each resident contact, that staff with communicable diseases or skin lesions does not have direct contact with residents or food, and that when a resident is in isolation that appropriate precautions are being followed. This monitoring will be completed weekly for 4 weeks for all residents using urinals, Nebulizer and oxygen equipment and for 5 staff for monitoring for handwashing and following isolation precautions. This monitoring will be documented and maintained by the Director of Nursing. Monitoring will start for the week of 1/21/2013. Then after the first 4 weeks of monitoring all residents and 5 staff, the monitoring will be conducted on 5 residents using urinals and 5 residents using nebulizer and/or oxygen equipment to ensure that nursing staff are cleaning equipment (urinals, nebulizer machines and masks after each treatment) and that the urinals, masks and tubing are stored in plastic bags, and that 5 staff are monitored</p>



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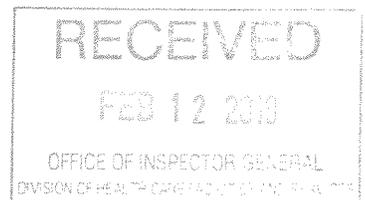
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F 441	Continued From page 18 Interview, on 12/28/12 at 3:40 PM, with the Assistant Director of Nursing (ADON) revealed oxygen equipment was to be stored in a plastic bag when not in use. The reason she gave for this was for infection control. She revealed the consequence to the resident for improper storage may be the resident's condition could worsen. She revealed the nurses were to monitor the equipment. Urinals, she revealed, were to be within reach of the resident. Not all residents place the urinals where they should be. She revealed anyone can explain to the resident why the urinal should be stored in an appropriate place. Interview, on 12/28/12 at 5:20 PM, with the Director of Nursing (DON) revealed staff had been in-serviced on infection control and the failure to follow infection control practices may result in infections. She revealed the nurses were responsible to monitor the facility for infection control., specifically, the ADON was responsible. She stated infection control rounds were done once a week, however, no documentation was made related to any findings or areas which may require follow up.	F 441	for handwashing and following isolation precautions for the next 11 months. This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate. With the correction of issues with the storage of nebulizer masks, nasal cannulas, urinals, and oxygen tubing, along with the staff education, and monitoring activities outlined in this plan of correction; the Continued on Page 19A



Continued From Page 19

facility will have established and be able to maintain an Infection Control Program that is designed to provide a safe, sanitary, and comfortable environment that will help prevent the development and transmission of disease and infection, as of 1/24/2013.

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1964

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type V (111)

SMOKE COMPARTMENTS: Four (4) smoke compartments

FIRE ALARM: Complete fire alarm system with heat and smoke detectors

SPRINKLER SYSTEM: Complete automatic wet (anti-freeze) sprinkler system.

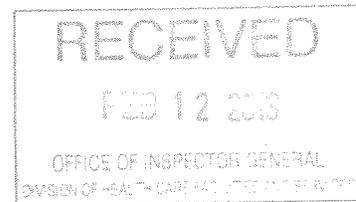
GENERATOR: Type II generator. Fuel source is natural gas.

A standard Life Safety Code survey was conducted on 12/27/12. Elizabethtown Nursing and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty five (65) beds with a census of fifty eight (58) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

K 000

This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.



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

TITLE

(X6) DATE

[Signature] X *[Signature]* X 2/12/13

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.

RW

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K 000 Continued From page 1

K 000

Deficiencies were cited with the highest deficiency identified at F level.

K 025 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 025

K025 Completion Date 1/25/2013
SS=F
NFPA 101 Life Safety Code Standard
Attic Smoke Barrier Penetrations

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 58.

Maintenance Manager fixed the smoke barrier, extending above the ceiling located in Heritage Hall that had penetrations of pipes and wires. The penetrations have been filled with a material rated equal to the partition and now can resist the passage of smoke. This work was completed on 1/17/2013.

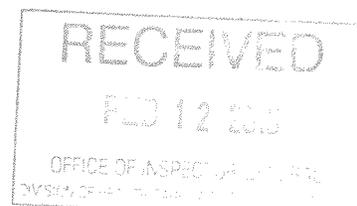
This STANDARD is not met as evidenced by:
Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a census of fifty eight (58) on the day of the survey.

Contracted vendor (Midwest Contracting, Inc.) fixed the smoke barrier on Lincoln Lane, by Room #36 that had penetrations of pipes and wires. The penetrations have been filled with a material rated equal to the partition and now can resist the passage of smoke. This work was completed on 1/24/2013.

The findings include:

Observations, on 12/27/12 between 10:00 AM and 11:00 AM, with the Maintenance Supervisor revealed the smoke barrier, extending above the ceiling located in Heritage Hall and Lincoln Lane

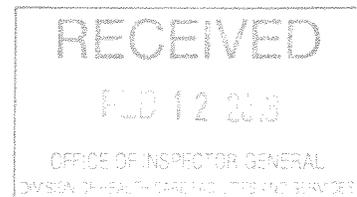
No other residents were identified as having the potential to be affected; however, day of inspection the census was at 58.



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K 025	Continued From page 2 by room #36 had penetrations of pipes and wires. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke Interview, on 12/27/12 between 10:00 AM and 11:00 AM, with the Maintenance Supervisor revealed he was not aware of the penetrations in the smoke barriers. Interview, on 12/27/12 at 2:245 PM, with the Administrator revealed she was aware of the requirements for smoke barriers but not aware of the penetrations in the smoke barrier. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall	K 025	Maintenance Manager checked all areas in the facility attic to ensure that no other areas needed repairs regarding smoke partition penetrations. No other areas were identified. This was completed on 1/17/2013. Administrator re-educated and trained the Maintenance Manager on 12/30/12 regarding the need for him to complete on-going inspections of the facility attic to check and repair smoke partition penetrations identified with his routine checks. These inspections will be conducted weekly for 4 weeks and then will be monthly. This will be added to his monthly TELS System monitoring starting the week of 1/20/2013. As stated above, the Maintenance Manager will do weekly inspections for 4 weeks starting the week of 1/20/2013, and then monthly thereafter to the facility attic areas for smoke partition penetration issues and will repair, as appropriate. Documentation of inspections and action taken will be completed and maintained by the Maintenance Manager by utilizing the TELS System. This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality		



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K 025 Continued From page 3
1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or
2. Be protected by an approved device designed for the specific purpose.
(c) Where designs take transmission of vibration into consideration, any vibration isolation shall
1. Be made on either side of the smoke barrier, or
2. Be made by an approved device designed for the specific purpose.

K 050 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty five (65) beds with a census of fifty eight (58) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times.

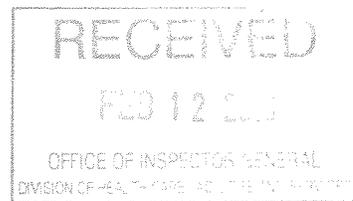
K 025 Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

K050 Completion Date 1/25/2013
SS=F
NFPA 101 Life Safety Code Standard
Fire Drills

No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 58.

No other residents were identified as having the potential to be affected; however, day of inspection the census was at 58.

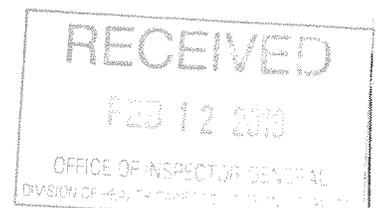
Administrator reviewed the fire drill regulations on 12/30/2012 for the



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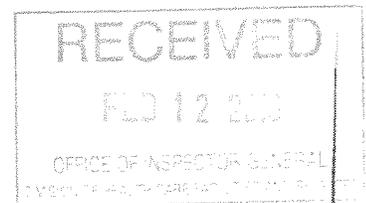
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K 050	<p>Continued From page 4</p> <p>The findings include:</p> <p>Fire Drill review, on 12/27/12 at 11:49 AM, with the Maintenance Supervisor revealed the facility failed to conduct fire drills at unexpected times on all shifts.</p> <p>Interview, on 12/27/12 at 11:49 AM, with the Maintenance Supervisor revealed they were not aware the fire drills were not being conducted as required.</p> <p>Interview, on 12/27/12 at 2:45 PM, with the Administrator revealed she was not aware of the requirements for conducting fire drills.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible</p>	K 050	<p>unexpected times for fire drills for the shifts and that the facility noncompliance was that fire drill unexpected times over a 12 month period did not include two hours spans throughout the different shifts. The Maintenance Manager was conducting more fire drills than required by regulation; however, time spans were the issue at hand.</p> <p>Therefore, on 1/2/2013, the Administrator re-educated and trained the Maintenance Manger on the regulations for fire drills and unexpected time requirements for the drills to be conducted within at least two hour spans during a 12 month period for the different shifts. In addition a fire drill schedule was developed for the facility for 2013 that meets the requirements from shift to shift and for the two hour span of time with drills. Maintenance Manager will implement this for 2013 effective for first drill for 2013 that will be 1/16/2013 at 10:00 a.m.</p> <p>The 2013 fire drill schedule that has been developed will be shared with the facility Quality Performance Improvement Committee. This committee will review the fire drill information each month for the next 12 months to ensure that fire drills are occurring according to the established schedule and will make recommendations as appropriate with the review of fire drill reports.</p>



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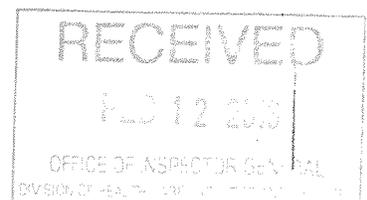
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K 050	Continued From page 5 alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure valves located in the facility sprinkler system were supervised by a tamper switch. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility has sixty five (65) certified beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 12/27/12 at 1:35 PM, with the Maintenance Supervisor revealed the main shut off valve on the sprinkler riser was not equipped with a tamper switch to notify the facility if the valve was closed. The valve was not equipped with a tamper switch that was electronically supervised; however, the valve was secured with a chain and padlock. Interview, on 12/27/12 at 1:35 PM, with the	K 061		K061 Completion Date 1/25/2013 SS=F NFPA 101 Life Safety Code Standards Sprinkler System Supervised Valves No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 58.



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K 061	<p>Continued From page 6</p> <p>Maintenance Supervisor revealed he was not aware the main valve on the sprinkler system was not supervised.</p> <p>Interview, on 12/27/12 at 2:45 PM, with the Administrator revealed she was not aware the main valve on the sprinkler system was not supervised.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves.</p> <p>Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.</p>	K 061	<p>No other residents were identified as having the potential to be affected; however, day of inspection the census was at 58.</p> <p>Administrator directed the Maintenance Manager on 12/30/2012, to contact the facility vendor, Vanguard Alarm Services to make arrangements for an electronically supervised tamper switch for the sprinkler system valves to be installed, that would alarm staff at the Heritage Hall nursing station of any valve switch problems. Vanguard installed and tested this electronically supervised switch by 1/24/2013.</p> <p>Maintenance Manger requested on 1/21/2013 that facility Director of Education/Training provide education and training to all facility staff regarding this electronically supervised switch and that it will alarm at the Heritage Hall nursing station when there are any problems/issues. When this occurs, nursing staff need to contact the</p> <p>K061 --- Continued on Page 7A</p> <p>K062 --- See Page 8</p>
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p>	K 062	



K061 --- Continued From Page 7

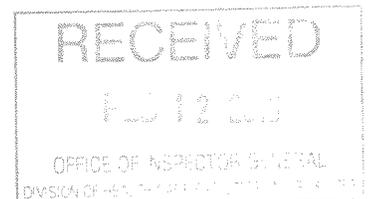
Maintenance Manager immediately. All staff were educated and trained to this by 1/24/2013. In addition post testing was completed to ensure for staff competency that was completed by 1/24/2013.

Maintenance Manager conducts a weekly inspection of this electronical switch valve that is monitored and documented in the TELS System. This inspection is to ensure that the electronical switch is working properly. This was effective for 1/24/2013.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when

K061 --- Continued on Page 7B

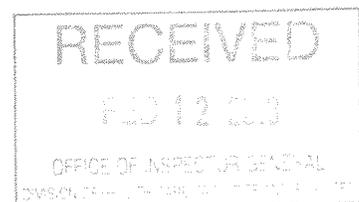
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K061 — Continued From Page 7A

monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

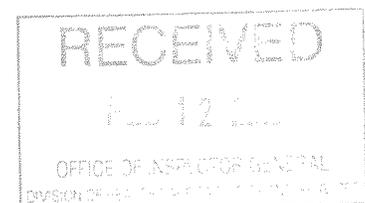
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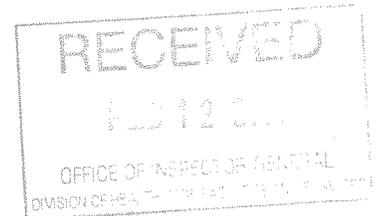
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/27/2012
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K 062	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings Include:</p> <p>Observation, on 12/27/12 at 10:19 AM, with the Maintenance Supervisor revealed wires supported by the sprinkler piping in the attic above the front Hall.</p> <p>Interview, on 12/27/12 at 10:19 AM, with the Maintenance Supervisor revealed he was not aware sprinkler piping could not be used to support wires.</p> <p>Interview, on 12/27/12 at 2:45 PM, with the Administrator revealed she was not aware sprinkler piping was being used to support wires in the attic over the front hall.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum</p>	K 062	<p>K062 Completion Date 1/25/2013 SS=D NFPA 101 Life Safety Code Standard Wires Sitting on Sprinkler System Pipes in Attic</p> <p>No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 58.</p> <p>Administrator directed the Maintenance Manager on 12/30/2012, to contact the facility vendor, Gene Ray Electric to make arrangements to correct this problem with wires sitting on a sprinkler system pipe in the attic of the facility. Our vendor, Gene Ray Electric corrected this issue on 1/3/2013.</p> <p>No other residents were identified as having the potential to be affected; however, day of inspection the census was at 58.</p> <p>Maintenance Manager inspected the work to ensure problem was corrected on 1/3/2013 and reported to the Administrator.</p> <p>Administrator re-educated and trained the Maintenance Manger on 12/30/2012 regarding the need for him to complete on-going inspections of the facility attic to check to make sure that wiring or any other materials or items are not sitting on</p>	



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K 062	<p>Continued From page 8</p> <p>requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1</p>	K 062	<p>sprinkler system pipes. Any problems identified will be addressed and corrected. These inspections will be conducted weekly for 4 weeks and then will be monthly. This will be added to the TELS System monitoring starting week of 1/6/2013.</p> <p>As stated above, the Maintenance Manager will do weekly inspections for 4 weeks starting the week of 1/6/2013 and then monthly to the facility attic areas for sprinkler system pipe issues with any wiring or any other materials sitting on pipes and will repair, as appropriate. Documentation of inspections and action taken will be completed and maintained by the Maintenance Manager by utilizing the TELS System.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI</p>	



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K 062 Continued From page 9
Exception No. 3
Sprinklers - fast response Test At 20 years and every 10 years thereafter
2-3.1.1 Exception No. 2
Sprinklers Test At 50 years and every 10 years thereafter
2-3.1.1
Valves (all types) Maintenance Annually or as needed Table 9-1
Obstruction investigation Maintenance 5 years or as needed Chapter 10

K 073 SS=F
NFPA 101 LIFE SAFETY CODE STANDARD
No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a census of fifty eight (58) on the day of the survey.

The findings include:

Observation, on 12/27/12 at 11:18 AM, with the Maintenance Supervisor revealed the facilities Flame Retardant Policy did not address seasonal decorations, or documentation that newly introduced personal decorations for residents had been treated with a flame retardant.

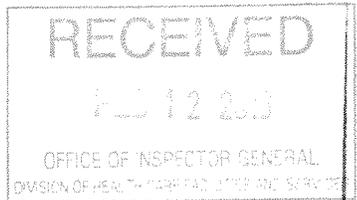
K 062 Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

K073 SS=F Completion Date 1/25/2013
NFPA 101 Life Safety Code Standard
Flame Retardant Policy --- Seasonal Decorations and Newly Introduced Resident Personal Decorations Treated with a Flame Retardant

No specific residents were cited in the statement of deficiency as having been affected; however, the day of inspection the census was at 58.

Administrator directed the Activity Director to take down all the facility Christmas seasonal decorations that were displayed on 1/3/2013.

No other residents were identified as having the potential to be affected; however, day of inspection the census was at 58.



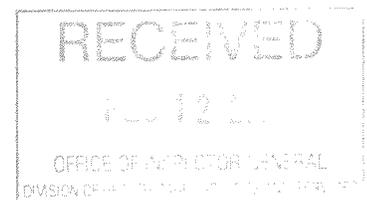
K073 Continued from page 11

treated and documentation of treatment is up-to-date. Staff competency regarding flame retardant requirements was completed through post testing and was completed by 1/24/2013. In addition, the Administrator re-educated and trained the Maintenance Manager regarding the need to keep a resident personal item inventory of items identified that need to be treated with flame retardant and documentation of when this was completed. This was completed on 1/3/2013. Maintenance Manager will start completing monthly inspections of any seasonal decorations that are being displayed in the facility and with resident personal items to keep his inventory of items that have been treated with flame retardant up-to-date. Any new decorations or items that were not previously inventoried will then be documented and treated with flame retardant. This monthly monitoring will start for January 2013 and will be on-going. Monthly monitoring reports will be reviewed by the administrator to ensure for on-going compliance.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement

K073 --- Continued on Page 11B

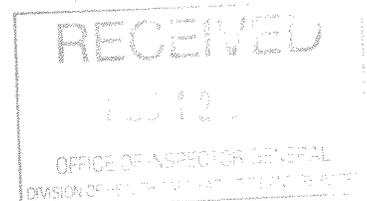
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K073 --- Continued From Page 11A

quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

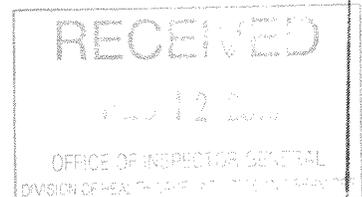
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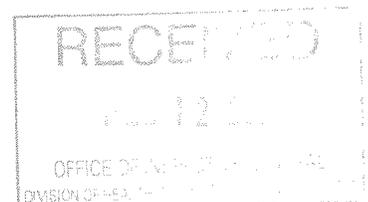
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K 144	<p>Continued From page 11</p> <p>determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/27/12 at 2:34 PM, with the Maintenance Supervisor revealed the generator's battery charger was hooked directly to the generator battery. Battery chargers cannot be hooked directly to the generator battery due to increase risk of fire.</p> <p>Interview, on 12/27/12 at 2:34 PM, with the Maintenance Supervisor revealed he was not aware that the battery charger could not be hooked directly to the battery.</p> <p>Interview, on 12/27/12 at 2:45 PM, with the Administrator revealed she was not aware that the battery charger could not be hooked directly to the battery.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with</p>	K 144	<p>K144 Continued from Page 11</p> <p>Maintenance Manager contacted our facility vendor, Vanguard and scheduled for them to come to the facility to correct the issue with the generator battery charger. This was corrected on 1/3/2013 by rewiring the generator battery charger to the generator starter and back to the battery charger instead of directly to the generator.</p> <p>No other residents were identified as having the potential to be affected; however, day of inspection the census was at 58.</p> <p>Maintenance Manager inspected the work that was completed by the facility vendor, Vanguard to ensure that the generator rewiring was completed as the invoice stated and communicated this to the Administrator. This was completed on 1/4/2013.</p> <p>Maintenance Manager conducts a weekly generator test that is monitored and documented in the TELS System. This test is to ensure that the generator starts automatically and shuts itself off automatically per timer settings. Maintenance Manager will submit documentation of the generator weekly testing that will be review for the next 12 months through the facility Quality performance Improvement Committee.</p>



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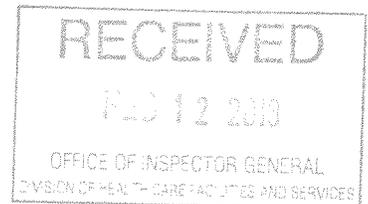
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K 144 K 147 SS=D	<p>Continued From page 12</p> <p>the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for sixty five (65) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 12/27/12 between 10:00 AM and 2:30 PM, with the Maintenance Supervisor revealed open electrical junction boxes located in the attic above the Front Hall. Further observation revealed storage in front of electrical panels located in the Boiler Room.</p> <p>Interview, on 12/27/12 between 10:00 AM and 2:30 PM, with the Maintenance Supervisor revealed he was aware of the open junction boxes but had just not repaired them. Further interview revealed he was not aware the items in</p>	K 144 K 147	<p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p> <p>K147 Completion Date 1/25/2013 SS=D NFPA 101 Life Safety Code Standards Open Electrical Junction Boxes in Attic and Storage in Front of Electrical Panels Located in Boiler Room</p> <p>No specific residents were cited in the statement of deficiency as having been</p>



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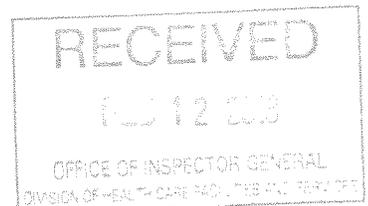
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K 147	<p>Continued From page 13</p> <p>the Boiler Room could not be stored in front of the electrical panels.</p> <p>Interview, on 12/27/12 at 2:45 PM, with the Administrator revealed she was not aware of the open electrical junction boxes in the attic. Further interview revealed she was aware items could not be stored in front of electrical panels.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric.</p> <p>Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p>	K 147	<p>affected; however, the day of inspection the census was at 58.</p> <p>Maintenance Manager contacted our facility vendor, Gene Ray Electrical and scheduled for them to come to the facility to correct the issue with the open junction boxes in the attic. This was corrected on 1/3/2013.</p> <p>Administrator directed the Maintenance Manager to remove the items stored in front of the electrical panels in the boiler room. This was corrected on 12/28/2012.</p> <p>No other residents were identified as having the potential to be affected; however, day of inspection the census was at 58.</p> <p>Maintenance Manager inspected the work that was completed by the facility vendor, Gene Ray Electrical to ensure that the open junction boxes had been capped as the invoice stated and communicated this to the Administrator. This was completed on 1/3/2013.</p> <p>Administrator checked the boiler room to ensure that all stored items had been removed from the front electrical panels. This was completed on 12/28/2012.</p> <p>Maintenance Manager conducted an inspection in the facility attic area to ensure that all junction boxes had caps on them. No other open junction boxes were</p>	



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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(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 147	<p>Continued From page 14</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>370 28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>Reference: NFPA 70 (1999 edition)</p>	K 147	<p>identified during this inspection. This inspection was completed on 1/3/2013.</p> <p>Administrator provided education and training to the Maintenance Manager regarding the hazards of storing items in the boiler room in front of the electrical panels and directed him not to ever do this. This was completed on 1/3/2013.</p> <p>Maintenance Manager will complete inspections of the facility attic area for 4 weeks, starting the week of 1/6/2013 to ensure that caps remain on all open junction boxes. Thereafter, for the next 11 months, the inspections will be conducted monthly. Maintenance Manager will maintain documentation of these inspections. Reports will be given to the Quality Performance Improvement Committee for review.</p> <p>Administrator will inspect the boiler room weekly for 4 weeks and then monthly for 11 months to ensure that items are not stored in this room, especially in front of the electrical panel. This inspection will start for the week of 1/6/2013.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement</p> <p>K147 — Continued on Page 15A</p>



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quality system where results will be reviewed and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance for the next 12 months. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, director of education & training, business office manager, social service director, and the administrator. The committee meets at least quarterly and more frequently as they deem necessary when monitoring plans of corrections. This PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

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