

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

PRINTED: 11/17/2011
FORM APPROVED
OMB NO. 0938-0391

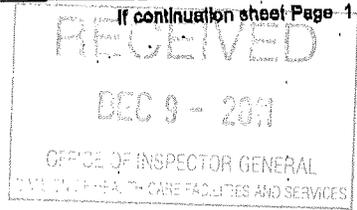
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2011
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING 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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's housekeeping schedule (undated), it was determined the facility failed to maintain clean heater vents in (thirteen) 13 resident rooms (#2, 5, 7, 9, 13, 17, 20, 21, 22, 23, 24, 25, and 30), on both units, and in the front day room of the facility. In addition, there were three (3) chairs and a love seat observed to be soiled. A resident's bedrail in Room 11A was noted to have dirty washcloths and gauze wrapped around it. The findings include: Review of the housekeeping cleaning log/schedule, on 11/09/11 at 5:00 PM, revealed no evidence that heater vents were included in	F 253	F253 SS=E 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	11/30/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator _____ (X8) DATE 11/30/11

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.



11/17/2011
 APPROVED
 0338-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 183286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE OF SURVEY COMPLETED 11/09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	

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F 253	<p>Continued From page 1 the cleaning schedule. A housekeeping policy regarding routine cleaning was requested, however, one was not provided during the survey.</p> <p>1. Observation, on 11/07/11 at 12:00 PM, revealed heater vents in Rooms 2, 5, 7, 9, 13, 17, 20, 21, 22, 23, 24, 25, and 30 had dust on the outside and inside the heater vents.</p> <p>Interview with the Administrator, on 11/09/11 at 4:30 PM, revealed the Housekeeping/maintenance department were responsible for cleaning the heater vents.</p> <p>Interview with the Housekeeping supervisor, on 11/09/11 at 6:00 PM, revealed they do not take the heater vents off to clean. The Housekeeping supervisor stated the heater vents are cleaned on Mondays, however, there was no evidence this was done throughout the survey.</p> <p>2. Observation of the front day room during the environmental tour, on 11/07/11 at 12:00 PM, revealed three (3) soiled chairs (dirty seats), and a love seat with a large brown circle in the center.</p> <p>Interview with the Administrator, on 11/09/11 at 4:30 PM, revealed it was time for the furniture to be cleaned, and stated she would look at the furniture yearly, and clean if needed. The Administrator further stated the furniture should be cleaned once a month but was not.</p> <p>3. Observation of Room 11A during the initial tour, on 11/06/11 at 6:00 PM, revealed an unsampled resident's side rail padded with dirty soiled gauze and dirty silk tape applied over it. Observation of the dirty gauze padding continued</p>	F 253	<p>1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>No residents were identified regarding soiled stains on the Heritage Lounge upholstered furniture. All of the upholstered furniture in the Heritage Lounge was professionally cleaned by an outside vendor --- Crutcher's (carpet cleaning and janitorial service cleaning company) on 11/22/2011.</p> <p>Resident's bed grab bar that was wrapped with white wash clothes and taped in place in Resident Room 11A was removed on 11/11/11 by the Director of Nursing.</p> <p>Resident Room heater registers and all the other heater registers in the facility were cleaned for dust removal by the Housekeeping Manager and Housekeeping Staff. All of this cleaning was completed by 11/28/2011.</p> <p>Administrator checked the work and cleanliness completion of all of the above mentioned environmental issues on 11/23/2011 for the furniture and 11/29/2011 for the heater registers and resident bed grab bars issue to assure that all deficient items were addressed and corrected.</p> <p>2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:</p>	
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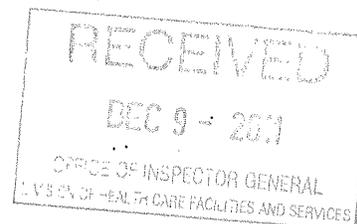
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 OFFICE OF INSPECTOR GENERAL
 STATE OF MISSISSIPPI HEALTH CARE FACILITIES AND SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	Continued From page 2 throughout the survey on 11/07, 11/08 and 11/09.	F 253	Continued on page 3A	
F 312 SS=E	<p>Interview with the Administrator, on 11/09/11 at 4:30 PM, revealed the gauze should not be there and stated they had removed several like that from the side rails prior to the survey.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's shower tracking records, it was determined the facility failed to provide necessary services to maintain good personal hygiene for four (4) of sixteen (16) sampled residents. Residents # 1, 3, 7, and #13 did not receive showers/baths as scheduled to maintain good personal hygiene.</p> <p>The findings include:</p> <p>Review of the facility's Policy and Procedure regarding Personal Needs, revised January 2007, revealed the facility would strive to promote a healthy environment and prevent infection by meeting personal care needs of the residents, and provide support when the resident performs their activities of daily living (ADLs). The Plan of Care will address the individual needs and preferences of the resident. Personal care and</p>	F 312	<p>F312 SS=E 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Director of Nursing ensured that Residents #1, #3, #7, #8, #11, and #13 received the necessary personal hygiene and grooming services of their choice on 11/09/2011. In addition, all other residents unable to carry out ADL's were assessed by the Director of Nursing on 11/09/2011 to ensure the necessary personal hygiene and grooming services of their choice were being provided.</p> <p>2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Director of Nursing and Assistant Director of Nursing completed a 100% audit of all residents in the</p>	11/30/2011

Continued on page 4



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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

188266

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

11/17/2011

NAME OF PROVIDER OR SUPPLIER

ELIZABETHTOWN NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1101 WOODLAND DRIVE
ELIZABETHTOWN, KY 40301

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F 253	<p>Continued From page 2</p> <p>All resident upholstered furniture in the Heritage Lounge was checked by the Administrator after the professional cleaning on 11/23/2011 to assure that none were soiled or stained. No soiled stains were noted. The Director of Nursing and Assistant Director of Nursing completed an audit to check all the resident beds with grab bars to assure that no others were wrapped and taped. The 100% audit demonstrated that no other deficient practice existed. This audit was completed on 11/11/2011.</p> <p>The Housekeeping Manager completed a 100% audit to assure that all heater registers throughout the facility (Heritage Lounge, Hallways, Dining Room, Kitchen, Offices, Laundry, and Resident Rooms) were cleaned and dust removed. The completion date for this audit and cleaning was completed on 11/28/2011.</p> <p>3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>The Administrator met with the Housekeeping Manager to develop and implement a check and cleaning process for the upholstered furniture in Heritage Lounge on 11/15/11. This check and cleaning process will consist of the Housekeeping Manager and Housekeeping Staff, when doing the weekly deep clean of</p>		F 253	<p>they will be spot cleaned. Any cleaning to the upholstered furniture in the Heritage Lounge will be documented on a cleaning sheet that will be maintained by the Housekeeping Manager. This will start for the week of November 27, 2011. In addition, the Housekeeping Manager will maintain records of deep cleaning of this furniture, to assure that it is thoroughly cleaned at least every 6 months, so that it remains clean. Director of Nursing did in-service training for all staff on 11/16/2011 and 11/18/2011 regarding the unacceptable practice of wrapping and taping a resident's bed grab bars with any material. Staff were instructed not to do this and if any were ever discovered to immediately report this to Director of Nursing or Assistant Director of Nursing for immediate correction. The Administrator met with the Housekeeping Manager to develop and implement an on-going cleaning schedule to assure that routinely the heater registers are cleaned and free of dust. The cleaning of heater registers in the facility will be scheduled quarterly starting for 4th quarter of 2011. First cleaning of all heater registers was started on November 10, 2011 and was completed on 11/28/2011. The Housekeeping Manager will maintain records of heater register cleaning for documentation that cleaning occurred as scheduled.</p> <p>Continued on page 3B</p>	

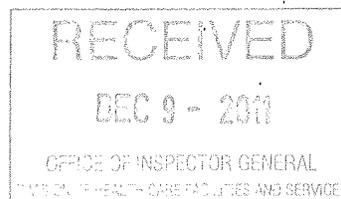
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1FCE11

Facility ID: 100161

If continuation sheet Page 3 of 18

the Heritage Lounge will check all the upholstered furniture and if there are soiled or stain places,



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F 253	Continued From page 3A 4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED, AS FOLLOWS: Housekeeping Manager will complete a weekly audit to make sure that Housekeeping Staff are addressing and spot cleaning any soiled and stained spots on upholstered furniture in Heritage Lounge. This weekly audit will start for the week of 11/27/2011 and will continue for the next 12 weeks. After this initial compliance monitoring, the Housekeeping Manager will maintain a cleaning schedule to ensure for at least a 6 month deep cleaning of this furniture to make sure it remains clean. The Housekeeping Manager will be required to maintain documentation of these audits and furniture cleaning. Director of Nursing or Assistant Director of Nursing will complete weekly audits of residents bed grab bars to assure that unacceptable practice of wrapping and taping these is not found. Any unacceptable practice of this discovered will be corrected immediately. This weekly audit will start for the week of 11/20/2011 and will continue for the next 12 weeks. The Director of Nursing or Assistant Director of Nursing will be required to maintain documentation of these weekly audits.		F 253	Housekeeping Manager will implement and audit quarterly to assure that heater registers throughout the facility are cleaned and free of dust on a quarterly basis, starting for 4 th quarter of 2010. The Housekeeping Manager will be required to maintain documentation of these quarterly audits and cleaning documentation. This Plan of Correction for Environmental Sanitary compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality committee for ensuring on-going compliance for the next 3 months. If at any time, concerns are identified during this monitoring process, the Performance Improvement Quality committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	

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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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F 312	Continued From page 3 ADL support will be provided according to the resident's need. 1. Observation of Resident #7, on 11/06/11 at 6:15 PM, revealed the resident sitting on the side of the bed with the family at bedside. The resident was dressed in clean street clothes but the resident's hair appeared to be dirty. The resident voiced his/her hair had not been washed for over a week. Continued interview with the resident and family during the tour observation revealed the facility had not assisted the resident with bathing needs for over a week. The resident voiced concern that he/she had not been offered a shower for over a week. The resident stated showers were scheduled for Tuesday and Fridays; however, the resident was not offered assistance the week of 10/31/11 thru 11/5/11. The resident stated he/she had put on clean clothes daily but felt "dirty". Family visiting at that time validated the resident had informed them showers/baths were not given as scheduled. The daughter stated she had requested a shower for the resident last week and was told by the evening staff one would be given. However, the resident and family stated this did not occur. Review of Resident #7's clinical record revealed the facility admitted the resident on 10/13/11. Review of the admission MDS (minimum data set) assessment dated 10/20/11 revealed the resident required extensive assist with bathing, dressing, and personal hygiene. The MDS assessment revealed the resident had indicated it was very important to chose daily preferences of bathing (showers, bed baths, sponge baths, or	F 312	facility on 11/10/2011, to ensure they were receiving personal hygiene and grooming services, as outlined on the nursing assistants care guideline sheets. 3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Director of Nursing provided re-training to all nursing staff and nursing assistants on 11/16/2011 and 11/18/2011 about providing the necessary personal hygiene and grooming services that are specified on each resident's plan of care or nursing assistant care guideline sheet. In addition, Director of Nursing updated all residents' plans of care to reflect their preferences of personal hygiene and grooming services on 11/10/2011. This was accomplished by interviewing the residents themselves and family members along with using the MDS.		

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F 312	<p>Continued From page 4 tub bath). The facility assessed the resident to be continent of bowel and bladder.</p> <p>Review of the Daily Plan of Care form (used by the nursing assistants to provide care to residents), with revision date of 11/04/11, revealed Resident #7 was to receive showers on Tuesdays and Fridays on the evening shift with assist of one. Review of the bath detail report (10/13/11-11/8/11) revealed the resident had received five (5) showers out of eight (8) showers scheduled. The report indicated the resident received twenty-one (21) bed baths during the same time period. However, closer review of the report revealed documentation of a bed bath 2-3 times a day on 10/19/11 and 10/30/11. The report also revealed twenty-two (22) different nurse aides documented on the bath detail report.</p> <p>Interview with the Director of Nursing (DON), on 11/09/11 at 2:30 PM, revealed she had only been in that position for three weeks. She stated she had received complaints from the evening shift nurse aides regarding not being able to complete all the assigned showers. She stated when she reviewed the shower assignment sheet she identified there were too many showers scheduled for the evening shift. She indicated the evening staff had attempted to give showers but were unable to complete all scheduled showers and would attempt to at least give a sponge bath. She stated she had reviewed the bath detail reports daily and through the documentation it appeared residents were getting showers/baths as scheduled. However, she revealed she had not asked any residents or families to ensure the showers/baths documented were actually getting done. When the DON reviewed the bath detail</p>	F 312	<p>4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED, AS FOLLOWS: Director of Nursing or Assistant Director of Nursing started completing a daily audit on 11/09/2011 using a CareTracker Report entitled, "Group Bathing" to ensure that all residents (to include the residents unable to carry out their ADL's) are receiving the necessary services to maintain good personal hygiene and grooming. This auditing will continue for a 12 week period. Any issues discovered through this auditing will be addressed and corrected immediately. Director of Nursing or Assistant Director of Nursing are responsible for maintaining this documentation to ensure compliance.</p>	
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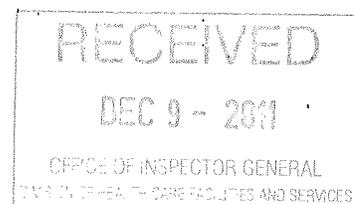
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F 312	<p>Continued From page 5</p> <p>report with the surveyor on 11/09/11, the DON indicated there was a large number of bed baths given for Resident #7 and stated maybe a bath was given after incontinent care. However, Resident #7 is continent of bowel and bladder.</p> <p>In addition, Resident #7 was re-interviewed, on 11/09/11 at 6:00 PM, that revealed the resident had never received a bed bath or sponge bath since admission on 10/13/11. The resident stated he/she preferred showers and did not want a bed bath as long as they were able to take a shower.</p> <p>Interview with the unit manager, on 11/09/11 at 3:00 PM, revealed she was responsible for both units. She indicated the method used to monitor completion of showers/baths was to review the bath detail reports. She stated these reports were reviewed daily at the morning meetings for compliance. She did not ask residents or families if they were getting showers/baths as scheduled. She stated she would ask if a resident's appearance looked bad or if a resident had skin issues.</p> <p>2. Review of the clinical record for Resident #1, revealed the facility admitted Resident #1 on 06/15/09 with diagnoses of Dementia and Depression. The facility completed a quarterly Minimum Data Set (MDS) assessment on 10/04/11 and assessed the resident as requiring extensive assistance of two (2) persons for hygiene and bathing. The facility determined the resident was nonverbal, incontinent of bowel and bladder, unable to ambulate or turn self in bed and unable to make decisions regarding personal care needs.</p>	F 312	<p>This Plan of Correction for Personal Hygiene and Grooming compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality committee for ensuring on-going compliance for the next 3 months. If at any time, concerns are identified during this monitoring process, the Performance Improvement Quality committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>	

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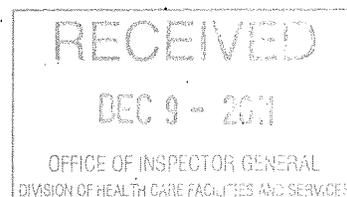
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F 312	Continued From page 6 Review of Resident #1's comprehensive Care Plan for Activities of Daily Living (ADL) completed by the facility on 09/30/11, revealed the resident required the assistance of one (1) person or two (2) persons for a shower. Review of the Daily Plan of Care, dated 11/08/11, revealed the facility developed a schedule for Resident #1's showers every Wednesday and Saturday and the resident required the assistance of two(2) staff members. Review of the facility's care tracking system dated 10/09/11 through 11/09/11, revealed no documentation that the facility showered Resident #1 on 10/29/11 and 11/02/11. Interview with Certified Nurse Aide (CNA) #1, on 11/09/11 at 2:30 PM, revealed the facility scheduled two baths per week for each resident. She indicated nursing staff were trained to follow the daily care plan in regards to when showers were scheduled. She stated nursing staff sometimes were too busy or were short staffed and a shower may have been missed. 3. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 12/02/10 with diagnoses of Advanced Alzheimer's Disease and Cachexia. The facility completed a quarterly MDS assessment on the resident on 09/07/11 which revealed the resident was not able to make daily care decisions, was	F 312		



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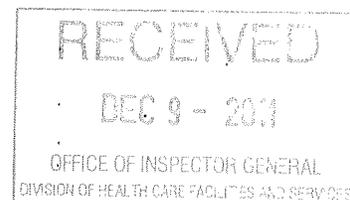
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 312	<p>Continued From page 7</p> <p>incontinent of bowel and bladder, non-ambulatory and required extensive assistance with dressing, hygiene, and bathing.</p> <p>Review of Resident #13's comprehensive Care Plan, dated, 09/06/11, revealed the facility would bath the resident with two (2) assistants.</p> <p>Review of the Daily Care Plan revealed the facility would provide Resident #13 with a shower on Wednesday and Saturday.</p> <p>Review of the facility's care tracker documentation from 10/09/11 through 11/09/11, revealed the facility showered Resident #13 on 10/10/11, 10/17/11, 10/24/11, 10/27/11, and 10/31/11. There was no other facility documentation to show the resident was showered twice a week.</p> <p>Interview with CNA #2, on 11/09/11 at 2:40 PM, revealed the facility developed a twice a week shower schedule for residents. She indicated the CNA may have given a bed bath. She stated the facility had not trained staff on the difference between a bed bath and perineal care.</p> <p>4. Observation of Resident #3, on 11/08/11 at 7:00 PM, revealed the resident was in bed on his/her back with the head of the bed up 30 degrees. Both of the resident's hands were contracted and the resident appeared to be debilitated. Interview with the resident, on 11/08/11 during the initial tour at 5:30 PM, revealed he/she did not get their showers as</p>	F 312		



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

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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 11/09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 312	<p>Continued From page 8</p> <p>scheduled. The resident stated he/she had not received a shower on 10/28/11 or 11/01/11, as scheduled.</p> <p>Review of Resident #3's admission comprehensive assessment, dated 10/04/11, revealed the resident required total assistance with bathing, and was care planned with the potential for activities of living (ADL) deficit, related to chronic immobility syndrome, quadriplegia, weakness, contractures, required an air mattress with bolsters, and mechanical lift for transfers with two assist.</p> <p>Review of the shower schedule, which indicated what day showers were given by staff, validated the resident's interview on tour related to not receiving showers. Review of the schedule revealed the resident was to be given showers on Tuesdays and Fridays, however, the schedule revealed only 1 shower per week had been given during the month of October.</p> <p>Interview with the Unit Manager (UM), on 11/09/11 at 3:00 PM, revealed there had been a problem with showers for a few months. She stated she was responsible for both units and had monitored showers/baths by pulling the shower records and completing rounds once a week, then taking them to the morning meeting.</p> <p>Interview with the Director of Nursing, on 11/09/11 at 2:30 PM, revealed there had been problems with too many showers being scheduled on the evening shift and the staff were unable to give the amount of showers. The DON stated she monitored showers by reviewing the bath detail</p>	F 312			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		DATE OF SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 312	Continued From page 9 records daily and it appeared the residents were getting their showers/ baths. However, further interview revealed she had not asked residents or families if baths were actually getting done. 5. A group interview with seven (7) unsampled alert and oriented residents, on 11/07/11 at 3:00 PM, revealed they did not always receive their showers as scheduled, and the showers were often left for the next shift to do. One unsampled resident stated he/she had been in the facility for one week, and had not received a shower. In addition, the resident received no help to wash. The resident stated, "I'm going home today and that is why!" Interview with the Administrator, on 11/09/11 at 5:00 PM, revealed she had a least three (3) residents report to her that they did not get their scheduled showers. She stated she investigated and treated these as individual concerns. She did not ask other residents if they had received their scheduled showers; therefore, did not identify there was a problem with showers getting done on the evening shift. She stated when the new DON was hired, the evening shift staff went to her and told her the shower schedule was too heavy. She indicated the bath detail reports are reviewed at the morning meetings; however, had not identified bed baths were documented daily or twice a day on some residents. She revealed she had not asked each resident or family member if showers were being given when the problem was first identified in October 2011.	F 312			
F 371 SS-F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371	F371 SS-F 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	11/30/2011	

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 _____
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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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F 371	<p>Continued From page 10</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to store and prepare food under sanitary conditions. Tour of the kitchen, on 11/08/11 at 4:40 PM, revealed food debris all over the serving area and a pile of dirt and food debris swept into a corner of the kitchen. The drawer that contained serving scoops and ladles had food debris and black flakes in the bottom of the drawer. The freezer temperature was 30 degrees F.</p> <p>The findings include:</p> <p>1. Observation during the initial tour of the kitchen, on 11/06/11 at 4:40 PM, revealed the food freezer had two food thermometers located inside the freezer. One thermometer had a reading of 30 degrees F, and one had a reading of 40 degrees F. Observation revealed the ice cream cups were soft.</p> <p>Interview with the dietary manager at the time of the above observation revealed the freezer was in defrosting mode.</p> <p>Observation of the food freezer, on 11/07/11 at</p>	F 371	<p>1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>The walk-in freezer was not maintaining appropriate temperatures when the survey first started on 11/6/2011 and 11/07/2011. The Maintenance Manager looked at the walk-in freezer and discovered that temperatures were not being maintained because boxes of frozen food were stored in a way that was preventing the fan in the freezer from working properly. Maintenance Manager corrected this problem on 11/08/2011. On 11/09/2011 the walk-in freezer was maintaining temperatures that were recorded -10 degrees. The Dietary Manager continued to monitor the walk-in freezer temperatures and from 11/08/2011 thru 11/11/2011, the recorded readings for the walk-in freezer have been maintained at the -10 degrees.</p> <p>The scoop drawer in the kitchen was found to be dirty when the surveyors started the survey on 11/06/2011. The Dietary Manager and Dietary Staff cleaned the scoop drawer on 11/06/2011 and it has been cleaned every day since.</p> <p>The kitchen floor was found to be dirty when the surveyors started the survey on 11/06/2011. The Dietary Manager and Dietary Staff cleaned the kitchen floor on 11/06/2011 and it has been cleaned every day since.</p>	
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STATE HEALTH CARE FACILITIES AND SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 40301	
(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 CROSS-REFERENCED TO THE DEFICIENCY)	(X6) COMPLETION DATE
F 371	<p>Continued From page 11</p> <p>12:00 noon, revealed a temperature of 20 degrees F. There were multiple boxes of food on the shelves and floor of the freezer. The ice cream was soft.</p> <p>Interview with the dietary manager at that time revealed the staff had been in and out the freezer in preparation for the lunch meal. In addition, she stated a food delivery was received earlier that morning with the door to the freezer opened frequently.</p> <p>On 11/08/11 at 2:00 PM, observation of the freezer revealed a temperature of 30 degrees F. Interview at that time with the dietary manager revealed she had replaced the thermometer in the freezer with a new one and the temperature still had not decreased. She stated she had notified the maintenance department of the problem. On 11/09/11, the food freezer temperature had reached negative (-) 10.</p> <p>Interview with the Maintenance Director, on 11/09/11 at 8:30 AM, revealed he had turned the freezer's thermostat down to reach the acceptable temperatures. He stated when the outside air temperature rise (it was 70-74 degrees F during the survey) you must adjust the thermostat.</p> <p>Review of the freezer temperature log for November and October revealed temperatures of 0 degrees F.</p> <p>2. Observation during the tour of the kitchen, on 11/06/11 at 4:40 PM, revealed dirt and food debris on the floor of the serving area. A pile of dirt and food debris had been swept into a corner of the</p>	F 371	<p>2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:</p> <p>Dietary Manager has continued to monitor the walk-in freezer temperatures daily since the survey, from 11/12/2011 thru 11/30/2011, and all the recorded walk-in freezer temperatures have been at -10 degrees, or lower.</p> <p>Dietary Manager has continued to monitor the scoop drawer daily since the first day of the survey (11/06/2011), and has found it to be cleaned. Dietary Manager is maintaining documentation of dates the scoop drawer has been inspected and findings. Any problems have been corrected on the spot.</p> <p>Dietary Manager has continued to monitor the kitchen floor daily since the first day of the survey (11/06/2011), and has found it to be cleaned. Dietary Manager is maintaining documentation of dates the kitchen floor has been inspected and findings. Any problems have been corrected on the spot.</p> <p>3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>Dietary Manager provided in-service training to all dietary staff on 11/14/2011 to ensure that they do not stack frozen food items or boxes in front of the walk-in freezer fan. Also, the</p>	

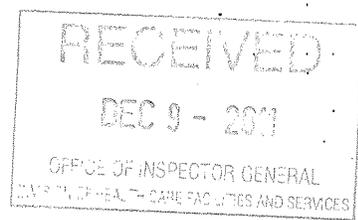
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE: 11/30/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	

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F 371	Continued From page 12 kitchen and left. The drawer that contained the serving ladles, scoops, and other utensils had black flecks and food debris on the bottom of the drawer. The drawer did not have any shelf paper and the serving utensils touched the black flecks and food debris. Interview with the dietary manager at the time of the observation revealed a dietary worker had called in and she was working in her place. She revealed there was only one other dietary staff working at that time. She stated she had not had time to clean the floor or the drawer because she had been busy preparing the evening meal.	F 371	dietary staff were instructed on monitoring the walk-in freezer temperatures and recording them on the temperature log. All of this in-service training was completed on 11/16/2011. Continued on page 13A	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F441 SS=E 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Assistant Director of Nursing cleaned all medication carts at the facility with the proper disinfectant to help prevent the development and transmission of disease and infection. This was accomplished on 11/18/2011. 2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Assistant Director of Nursing cleaned all	11/30/2011

Continued on page 14.



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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 _____

11/09/2011
REVISED
11/09/2011

NAME OF PROVIDER OR SUPPLIER

ELIZABETHTOWN NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
**1104 WOODLAND DRIVE
ELIZABETHTOWN, KY 42701**

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 13</p> <p>Administrator met with the Dietary Manager on 11/09/2011 and instructed her to monitor the walk-in freezer temperatures daily, starting on 11/09/2011. No problems have been noted with this monitoring since it started. Dietary Manager is responsible for maintaining these walk-in freezer temperature logs as documentation of the daily monitoring.</p> <p>Administrator met with the Dietary Manager on 11/11/11 regarding the development and implementation of a cleaning schedule for the scoop drawer in the kitchen. Dietary Manager has added this to the daily cleaning schedule as of 11/11/11. Scoop drawer cleaning will be documented on this cleaning log by the Dietary Manager and Dietary Staff. Dietary Manager will monitor the cleaning of the scoop drawer daily to ensure that this scoop drawer remains clean at all times.</p> <p>Dietary Manager provided in-service training to all dietary staff on 11/14/2011 to ensure that they understand and are knowledgeable about the need to clean the scoop drawer in the kitchen daily and to document on the cleaning log that this task was completed. All of this in-service training was completed on 11/16/2011.</p> <p>Administrator met with the Dietary Manager on 11/11/11 regarding the development and implementation of a cleaning schedule for the kitchen floor cleaning. Daily kitchen floor</p>		F 371	<p>they understand and are knowledgeable about the need to do daily cleaning of the kitchen floor and to document on the cleaning log that this task was completed. All of this in-service training was completed on 11/16/2011.</p> <p>4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED, AS FOLLOWS:</p> <p>Dietary Manager and Dietary Staff will complete walk-in freezer temperature log monitoring daily, starting 11/09/11 and this will continue for 3 weeks (through 11/30/2011). Temperature log documentation for the walk-in freezer will continue but Dietary manager will monitor this 3 x week for the next 9 weeks. Dietary Manager will maintain the documentation that demonstrates this monitoring was completed.</p> <p>Dietary Manager will complete monitoring to ensure that scoop drawer in the kitchen is cleaned daily for 3 weeks (through 12/02/2011). Scoop drawer checks and cleaning logs will be monitored by the Dietary Manager 3 times weekly for the next 9 weeks. Dietary Manager will maintain the documentation that demonstrates this checking and monitoring was completed.</p> <p>Dietary Manager will complete kitchen floor cleaning monitoring, starting 11/11/11 and this will continue daily for 3 weeks (through 12/02/2011). Floor inspections and cleaning logs will be monitored by the Dietary manager 3 times weekly for the next 9 weeks. Dietary Manager will maintain the documentation that demonstrates this checking and monitoring was completed.</p>	

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cleaning will be documented on the cleaning log by the Dietary Manager and Dietary Staff. Dietary Manager will monitor the daily cleaning of the kitchen floor daily to ensure for compliance with this cleaning requirement.

Dietary Manager provided in-service training to all dietary staff on 11/14/2011 to ensure that

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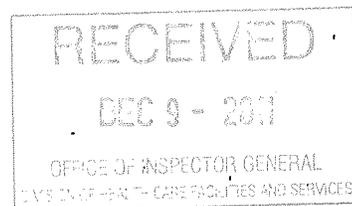
Facil This Plan of Correction for Dietary Sanitary compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality committee for ensuring on-going compliance for the next 3 months. If at any time, concerns are identified during this monitoring process, the Performance Improvement Quality committee will

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be convened to analyze and recommend any further interventions, as deemed appropriate.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE LOCATION INFORMATION A. BUILDING _____ B. WING _____	
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 MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 441	<p>Continued From page 13</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy, and facility medication cart cleaning schedule, it was determined the facility failed to maintain an effective infection control program in regard to sanitary medication carts for four (4) of four (4) medication carts inspected. The medication cart for Rooms 1-5 revealed dried substances on the top of the cart along with a soiled towel under the water pitcher. The pill crusher was soiled as was the outside of the cart. The medication cart for Rooms 6-17 revealed a soiled container for ice and items kept on ice. There were dried substances on the outside of the cart. The medication cart for Rooms 18-24 was soiled on the inside and the top and the pill crusher was soiled. The medication cart for Rooms 26-36 was soiled on the inside and on the top with the pill crusher soiled.</p>	F 441	<p>medication carts at the facility with the proper disinfectant to help prevent the development and transmission of disease and infection. This was accomplished on 11/18/2011.</p> <p>3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Director of Nursing re-educated and re-trained all licensed nursing staff on 11/16/2011 and 11/18/2011 about the process and procedure on properly cleaning medication carts. In addition, a medication cart cleaning schedule was developed and implemented on 11/18/2011. All nursing staff were educated regarding their responsibilities regarding the medication cart cleaning schedule during this training on 11/18/2011.</p> <p>4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED, AS FOLLOWS:</p>	



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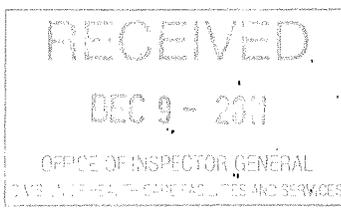
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE IDENTIFICATION NUMBER A. AGENCY: _____ B. WISCONSIN: _____	DATE OF REVIEW 11/09/2011
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NAME OF PROVIDER OR SUPPLIER
ELIZABETHTOWN NURSING AND REHABILITATION CENTER

ADDRESS, CITY, STATE, ZIP CODE
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
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F 441	<p>Continued From page 14</p> <p>The findings include:</p> <p>Review of the facility's Equipment-Cleaning/Disinfecting/Sterilization Policy, dated November 2011, revealed a facility specific cleaning schedule would be developed and included the cleaning of the medication and treatment carts. Carts were to be wiped down after every shift and medications were to be moved and the drawers were to be wiped down. Each nurse had a specific assignment for cleaning the medication carts.</p> <p>Observation of the medication carts, on 11/09/11 at 10:36 AM, revealed the cart for Rooms 1-5 had dried clear and white substances on the top and a sticky tape-like residue was present. A brownish stained towel was folded and under the water pitcher. The pill crusher had brownish debris in the corners and the outside of the cart and the bumper had dried substances and debris present.</p> <p>Observation of the medication cart for Rooms 6-17, on 11/09/11 at 10:35 AM, revealed the cart had a container filled with ice and items requiring ice. The container lid had a large amount of brown debris on the outside of the lid. The top and outside of the cart were soiled with dried substances. A container holding straws, cups and medication cups was covered with sticky tape-like residue.</p> <p>Observation of the medication cart for Rooms 18-24, on 11/09/11 at 10:35 AM, revealed the cart top was soiled with a sticky tape-like residue and dried substances. The pill crusher was soiled with a white substance. The outside of the cart</p>	F 441	<p>Director of Nursing or Assistant Director of Nursing will conduct daily audits for the next 4 weeks, starting on 11/21/2011 to ensure that all medication carts are cleaned according to the process and procedure and schedule implemented. After the initial four weeks, the auditing will reduce to one time weekly for the next 8 weeks, to ensure that medication carts continue to be cleaned as outlined above. Director of Nursing or Assistant Director of Nursing will be responsible for maintaining the documentation of these audits.</p> <p>This Plan of Correction for Pharmacy compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality committee for ensuring on-going compliance for the next 3 months. If at any time, concerns are identified during this monitoring process, the Performance Improvement Quality committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 11/09/2011
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 16</p> <p>was soiled with dried substances and smears. The ice container had a brownish substance on the outside of the lid. Observation of the inside of the cart revealed drawers with dried substances and debris.</p> <p>Observation of the medication cart for Rooms 26-36, on 11/09/11 at 10:35 AM, revealed the top of the cart was soiled with dried and sticky substances. The pill crusher had a whitish residue around the outside. The container holding ice and items required to be iced had a lid with a heavy presence of a brownish substance on the outside. The inside of the cart revealed dried white and clear substances.</p> <p>Interview with Registered Nurse (RN) #1, on 11/09/11 at 10:35 AM, revealed there was a facility cleaning schedule for the medication carts. She stated she was not aware of who supervised the cleaning of the carts. She stated the nurses had not cleaned the medication carts and they were soiled. She indicated soiled carts were infection control issues.</p> <p>Interview with the Director of Nursing (DON), on 11/09/11 at 2:30 PM, revealed she expected the nurses to keep the medication carts clean. She stated no one had been assigned to supervise this task.</p>	F 441			

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

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 11/09/2011
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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 11/09/11. Elizabethtown Nursing and Rehabilitation was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty-five (65) beds and the census was sixty-one (61) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	

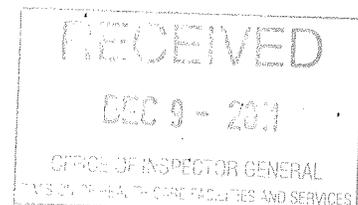
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator _____ (X5) DATE 11/30/11

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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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 11/09/2011
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 000	Continued From page 1	K 000		
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3.</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty-five (65) beds and the census</p>	K 018	<p>K018 SS=E NFPA 101 LIFE SAFETY CODE STANDARD Resident Room Doors Not Latching</p> <p>1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>Maintenance Manager corrected the problems with Resident Room Doors # 6 and # 14 not staying latched when fully closed on 11/22/2011.</p>	11/30/2011



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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 _____
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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 40301
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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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K 018	Continued From page 2 was sixty-one (61) on the day of the survey. The findings include: Observations, on 11/09/11 between 2:27 PM and 2:32 PM, with the Administrator and the Maintenance Director revealed the Resident's corridor doors to rooms 14 and 6 did not latch when tested. Interviews, on 11/09/11 between 2:27 PM and 2:32 PM, with the Administrator and the Maintenance Director revealed a confirmation that the doors would not latch and resist the passage of smoke. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar	K 018	2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Maintenance Manager completed a 100% audit of all doors in the facility to ensure they were staying latched when fully closed on 11/22/2011. No other doors in the facility required any correction. 3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator met with the Maintenance Manager on 11/14/2011 to educate him on the importance of routinely checking to ensure that all doors in the facility are latching correctly when fully closed.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING NUMBER - MAIN BUILDING 01 B. WING	(X3) SURVEY COMPLETED 11/09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GODLAND 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 018	Continued From page 3 auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 6 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or	K 018	<p>FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED AS FOLLOWS:</p> <p>Maintenance Manager will be performing weekly checks on all doors at the facility to ensure they stay latched when fully closed. This monitoring will start for week of 11/20/11 and will continue for the next 12 weeks. Any issues found with this monitoring will be corrected immediately. Thereafter, checking of the doors in the facility will be added to the Maintenance Manager's preventive maintenance schedule as a task to completed and document compliance.</p> <p>This Plan of Correction for Resident Rooms and other doors throughout the facility not latching correctly will include</p>	

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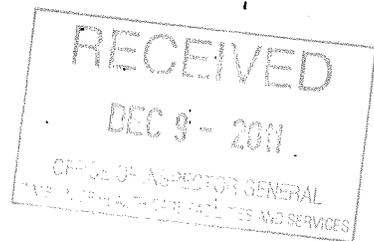
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	DATE: 11/09/2011
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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 40301
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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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K 018	Continued From page 4 plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	compliance monitoring that is integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	11/30/2011
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 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, according to NFPA standards. The deficiency had the potential to affect two (2) of the six (4) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-five (65) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observation, on 11/09/11 at 12:55 PM, with the Administrator and the Maintenance Director	K 025		

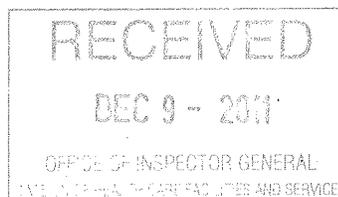


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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 40301	
(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 025	<p>Continued From page 5</p> <p>revealed the smoke partition extending above the ceiling, located between the Therapy Department and the Lincoln Lane corridor, had penetrations previously sealed with a non-rated sealant. Penetrations are required to be sealed with a material of the same fire resistant rating as the partition.</p> <p>Interview, on 11/09/11 at 12:55 PM, with the Administrator and the Maintenance Director revealed they were unaware of the penetrations in the smoke partitions, not being sealed with the proper, rated material.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 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. <p>(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</p> <ol style="list-style-type: none"> 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. <p>(c) Where designs take transmission of vibration</p>	K 025	<p>No specific residents were cited in the Statement of Deficiency as having been affected; however the day of inspection the census was at 61.</p> <p>Maintenance Manager fixed all areas in the attic area on Lincoln Lane that had been sealed with spray foam on 11/16/2011. This was corrected by removing the spray foam and replacing it by sealing the areas with plaster.</p> <p>2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:</p> <p>No other residents were identified as having the potential to be affected; however, day of inspection the census was at 61.</p>	

Continued on page 6A



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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: _____	DATE OF SURVEY 11/08/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1181 WOODLAND DRIVE ELIZABETHTOWN, KY 40301	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE
K 025	Continued From page 8. Maintenance Manager checked all areas in the facility attic to ensure that no other areas had been sealed with the spray foam. No other areas were identified. This was completed on 11/16/2011. 3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator re-educated and trained the Maintenance Manager on 11/11/2011 regarding acceptable materials to utilize when sealing penetration areas in the attic --- has to be materials rated the same as the wall materials to meet fire safety codes and spray foam		K 025	4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED AS FOLLOWS: When the Maintenance Manager identifies any other areas that need to be sealed that are penetration areas for fire, that Administrator be consulted to ensure that acceptable materials to seal the penetration areas are utilized for the repair. This is effective as of 11/16/2011 and will continue for the next 12 weeks for monitoring purposes. This Plan of Correction for Sealing Fire Penetration Area compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the	

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does not have the same rating and is an unacceptable material to use.

Event ID: 1FCE21

Facility ID: 100181

If continuation sheet Page 6 of 20

Performance Improvement 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) MULTI-FACILITY A. BUILDING: 01 - MAIN BUILDING 01 B. WING: _____	DATE OF DEFICIENCY: 11/09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 WOODLAND DRIVE ELIZABETHTOWN, KY 40301	
(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 CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 6 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 025		
K 058 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty-five (65) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observation, on 11/09/11 at 2:00 PM, with the	K 058	K056 SS=E NFPA 101 LIFE SAFETY CODE STANDARD Covered Front Porch Sprinklers on the Exterior 1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No specific residents were cited in the Statement of Deficiency as having been affected; however, the day of the inspection the census was at 61. On 11/23/2011, an outside vendor (Armor Fire Protection, LLC, installed three sprinklers under the covered front porch area of the facility.	11/30/2011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE DEFICIENCY A. BUILDING NUMBER: MAIN BUILDING 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 11/09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1107 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 066	Continued From page 7 Maintenance Director, revealed the front entrance porch was not protected by automatic sprinklers. The porch is approximately ten (10) feet by twenty-five (25) feet in area and constructed with combustible materials. Interview, on 11/09/11 at 2:00 PM, with the Maintenance Director revealed he was not aware the front entrance porch was required to be protected by automatic sprinklers. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. NFPA 101 LIFE SAFETY CODE STANDARD	K 056	2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No other residents were identified as having been affected; however, the day of the inspection the census was at 61.. Continued on page 8A	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe	K 066	Continued on page 9	11/30/2011

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) FACILITY TYPE A. BUILDING: 01 - MAIN BUILDING 01 B. WING: _____	12/2011 REVISED 12/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		ADDRESS, CITY, STATE, ZIP CODE 111 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE
K 056	Continued From page 8 On 11/23/2011, an outside vendor (Armor Fire Protection, LLC, installed three sprinklers under the covered porch area of the facility. 3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator re-educate and trained the Maintenance Manager on 11/11/2011 regarding the Life Safety Code Regulations regarding a covered porch area that exceeds 4 feet must be have sprinklers installed for fire protection, even if the exterior is covered with metal.		K 056	If Maintenance Manager identifies any other sprinkler issues for fire safety, the Administrator will be consulted. The issue will be investigated to determine the corrective action needed to correct the issue for fire safety. This will be effective for 11/24/2011. For the next 12 weeks any such issues will be reported to and reviewed by the facility's Quality Improvement Committee. This Plan of Correction for Sprinkler compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	
	4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED AS FOLLOWS:				

DATE: 11/21/2011
 APPROVED
 NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING NO. 01 - MAIN BUILDING 01 B. WING _____	SURVEY COMPLETED 11/09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 40301	
(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 066	Continued From page 8 design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, according to NFPA standards. The deficiency had the potential to affect residents, staff and visitors. The facility is licensed for sixty-five (65) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observation, on 11/09/11 at 1:40 PM, with the Administrator and the Maintenance Director, revealed the designated smoking area located outside of the Kitchen area, had an open ash tray in use and no hot ash dump for tobacco product waste. Interview, on 11/09/11 at 1:40 PM, with the Administrator and the Maintenance Director revealed the ashtray in use, in the designated smoking area, was not of the approved type and could potentially pose a hazard to	K 066	K066 SS=D NFPA 101 LIFE SAFETY CODE STANDARD Smoking Ashtrays 1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No specific residents were cited on the Statement of Deficiency; however, on date of inspection the census was 61. Maintenance Manager discarded the smoking ashtray that was broken and replaced it with a new one that is metal with self-closing cover device on 11/9/2011. This is the designated employee only outside smoking area. 2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	11/30/2011

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No specific residents were cited on the Statement of Deficiency; however, on date of inspection the census was 61.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

DATE: 11/21/2011
FORM APPROVED
PHONE: 0938-0391

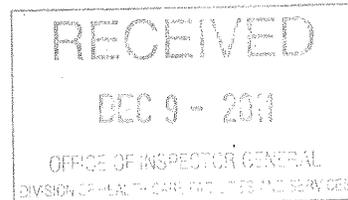
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MVA CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING:	DATE SURVEY COMPLETED 11/09/2011
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 140 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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K 066	Continued From page 9 residents, staff and visitors. Reference: NFPA 101 (2000 Edition). 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	Maintenance Manager discarded the smoking ashtray that was broken and replaced it with a new one that is metal with self-closing cover device on 11/9/2011. This is the designated employee only outside smoking area. In addition, Maintenance Manager checked the resident designated smoking area to ensure that proper ashtrays were available there and they were on 11/9/2011. 3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Continued on page 10A K074 NFPA 101 LIFE SAFETY CODE STANDARD Resident Shower Rooms' Shower Curtains	
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health	K 074		11/30/2011

Continued on page 11



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

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10/18/01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 WOODLAND DRIVE ELIZABETHTOWN, KY 42701

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 10 Administrator re-educated and provided training to Maintenance Manager on 11/11/2011 regarding the proper ashtrays that need to be available in designated smoking areas (resident one and employee one). 4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED AS FOLLOWS: Maintenance Manager will complete a daily (Monday -		K 066	Friday) audit for two weeks to ensure that proper ashtrays are available in the two designated smoking areas (employee and resident). This auditing started on week of 11/27/2011. Then for the next 10 weeks, the Maintenance Manager will do weekly auditing to monitor to ensure that acceptable ashtrays remain in the designated smoking areas. This Plan of Correction for using only acceptable ashtrays in designated smoking areas compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be	

convened to analyze and recommend any further interventions, as deemed appropriate

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DATE: 11/21/2011
ITEM APPROVED
NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MOC NUMBER A. BUILDING: 01 - MAIN BUILDING 01 B. WING: _____	DATE SURVEY COMPLETED 11/09/2011
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 110 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
K 074	<p>Continued From page 10</p> <p>care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were according to NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-five (65) beds and the census was sixty-one (61) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 11/09/11 between 1:20 PM and 2:30 PM, with the Administrator and the Maintenance Director revealed the privacy curtains within the Shower Rooms, located in both the Heritage Hall and Lincoln Lane, were of</p>	K 074	<p>1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>No specific residents were cited in the Statement of Deficiency as having been affected; however, the day of the inspection the census was at 61.</p> <p>Maintenance Manager ordered acceptable (mesh 18 inch top shower curtains) shower curtains on 11/11/11 and unapproved shower curtains were removed from the shower rooms on 11/29/11 on Lincoln Lane and Heritage Hall. Sign was placed on the outside of shower room doors to request staff knock to ensure no resident is in shower room before entering on 11/29/2011. Approved shower curtains will be installed as soon as received from the vendor.</p>	11/30/2011

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DATE: 11/21/2011
APPROVED
INT: 00938-0391

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: _____	DATE OF SURVEY COMPLETED 11/09/2011
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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)	(X6) COMPLETION DATE
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K 074	Continued From page 11 a solid fabric hung directly below the ceiling. The solid fabric would obstruct the spray pattern of the automatic sprinklers in the event of a fire. Interviews, on 11/09/11 between 1:20 PM and 2:30 PM, with the Administrator and the Maintenance Director revealed they were not aware of the requirements for proper operations of the sprinkler system and acknowledged that a solid fabric curtain could obstruct the spray pattern in the event of a fire. NFFA 13 Cubicle curtains; Reference to: NFFA 13 Standard for the Installation of Sprinkler Systems 1998 Edition 19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using a 1/2-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFFA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFFA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074	2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No other residents were identified as having the potential to be affected; however, on day of inspection the census was at 61. Maintenance Manager ordered acceptable (mesh 18 inch top shower curtains) shower curtains on 11/11/11 and unapproved shower curtains were removed from the shower rooms on 11/29/11 on Lincoln Lane and Heritage Hall. Sign was placed on the outside of shower room doors to request staff knock to ensure no resident is in shower room before entering on 11/29/2011. Approved shower curtains will be installed as soon as received from the vendor. Continued on page 12A	
K 076	NFFA 101 LIFE SAFETY CODE STANDARD	K 076		

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12/21/2011
APPROVED
18-0391

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 _____	KEY DATE 11/09/2011
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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 40301
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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE APPROPRIATE)	(X3) COMPLETION DATE	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 074	<p>Continued From page 12</p> <p>3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>Director of Nursing educated all nursing staff on 11/28/11 and 11/29/11 to the practice of knocking on shower room doors before entering to ensure that no resident is in the shower room having their personal care needs attended to until approved shower room curtains are received and installed. In addition, Housekeeping Manager educated his housekeeping staff to the same practice as outlined above on 11/29/11. Administrator re-educated and trained the Maintenance Manager and the Housekeeping Manager on 11/11/2011 regarding the need to install all shower curtains in the shower rooms on Lincoln Lane and Heritage Hall that have the 18 inch top mesh for fire</p>		K 074	<p>4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED AS FOLLOWS:</p> <p>Administrator instructed the Housekeeping Manager to removed all unacceptable shower curtains from the facility on 11/29/2011. In addition, the Housekeeping Manager will start completing a weekly audit for the week of 11/27/2011 that will continue for 12 weeks to ensure for compliance with only acceptable shower curtains being utilized in the shower rooms. Documentation of this audit will be the responsible of the Housekeeping Manager. This Plan of Correction for Shower Curtain compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring</p>	

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Facility ID: 100161

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safety. Administrator explained that these were the only acceptable shower curtains for the shower rooms. No other type of shower curtains should ever be used in the shower rooms.

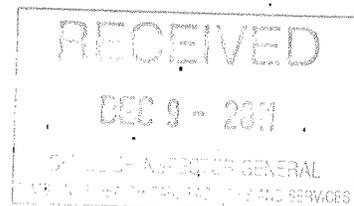
On-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

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DATE: 11/21/2011
FORM APPROVED
REV. NO. 0938-0391

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 _____		DATE SURVEY COMPLETED 11/09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 40301		
(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 076 SS=D	Continued From page 12 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored according to NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-five (65) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observation, on 11/09/11 at 2:10 PM, with the Administrator and the Director of Maintenance revealed two (2) oxygen cylinders located within the oxygen storage room, were not placed in a rack to prevent falling or being knocked over and not separated or identified as empty or full, as required by Code.	K 076	K076 NFPA 101 LIFE SAFETY CODE STANDARD SS=D Medical Gas Storage 1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: There were no specific residents that were cited in the Statement of Deficiency; however, on the date of inspection the census was at 61. Medical Records/Supply Clerk removed the two O2 e-tanks that were store in the O2 closet by contacting the vendor to come and get them on 11/11/11. 2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	11/30/2011	



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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 _____	
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 CORRECTIVE ACTION (EACH CORRECTIVE ACTION MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	Continued From page 13 Interview, on 11/09/11 at 2:10 PM, with the Administrator and the Maintenance Director, confirmed the observation of the oxygen cylinders not being stored properly. Reference: NFPA 99 (1999 Edition). 4-3.1.1.2 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 4-3.5.2.2 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. 4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. NFPA 101 MISCELLANEOUS	K 076	There were no specific residents that were cited in the Statement of Deficiency; however, on the date of inspection the census was at 61. Medical Records/Supply Clerk removed the two O2 e-tanks that were store in the O2 closet by contacting the vendor to come and get them on 11/11/11. Continued on page 14A	11/30/2011
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, per NFPA	K 130	K130 NFPA 101 MISCELLANEOUS Resident Room Bathroom Latches/Locks 1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No specific residents were cited in the Statement of Deficiency has having been affected; however, on the date of inspection the census was at 61..	

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Maintenance Manager removed the latch locks from all the resident bathroom doors and replaced them with a push button locks in the door knobs. This was completed on 11/22/2011.

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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
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 40301

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE
K 076	<p>Continued From page 14</p> <p>3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator re-educated and trained the Medical Records/Supply Clerk on 11/11/2011 regarding the proper storage of O2 e-tanks. In addition, all staff were re-educated and trained on proper storage of O2 e-tanks by the Director of Nursing on 11/16/2011 and 11/18/2011.</p> <p>4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED AS FOLLOWS: Administrator instructed Records/Supply Clerk on 11/11/2011 to contact facility vendor to request an O2 e-tank rack that can be stored in the O2 closet in case other O2 e-tanks</p>		K 076	<p>Records/Supply clerk will ensure that the O2 e-tank is stored appropriately in the rack in the O2 closet. O2 vendor is delivering a storage rack to the facility to be placed in the O2 closet on 11/29/11.</p> <p>Starting for week of 11/27/2011, the Medical Records/Supply clerk will conduct an audit to monitor to ensure that any O2 e-tanks in the facility are correctly stored and that appropriate O2 company is called to pickup the O2 e-tank. The documentation from this audit will be the responsibility of the Medical Record/Supply Clerk. This audit will be completed for 12 weeks to ensure compliance with O2 e-tanks being stored correctly in the facility.</p> <p>This Plan of Correction for O2 e-tank compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next</p>	

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Event ID: 1FC21

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If continuation sheet Page 14 of 20

get left at the facility. In addition, any time that an O2 e-tank gets left at the facility, Medical Records/Supply Clerk upon identifying this will call the appropriate O2 company to come and pick this up. Until O2 e-tank is picked up by the appropriate O2 company, the Medical

3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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: _____	
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)	(X3) COMPLETION DATE
K 130	Continued From page 14 standards. The deficiency had the potential to affect two (2) of the four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty-five (65) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observations, on 11/09/11 between 12:30 PM and 2:30 PM, with the Administrator and the Maintenance Director revealed unapproved locks (slide bolt type) were installed on the egress side of all toilet room doors located within each resident room. Interviews, on 11/09/11 between 12:30 PM and 2:30 PM, with the Administrator and the Maintenance Director revealed they were aware of the locks installed on the doors; however, they were not aware that slide-bolt locks were prohibited. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. NFPA 101 LIFE SAFETY CODE STANDARD	K 130	2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No other residents were identified as having the potential to be affected; however, on the date of inspection the census was at 61. Maintenance Manager removed the latch locks from all the resident bathroom doors and replaced them with a push button locks in the door knobs. This was completed on 11/22/2011. Continued on page 15A	
K 144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K144 NFPA 101 LIFE SAFETY CODE STANDARD SS=F Generator/Nursing Station Box (Annunciator Panel)	11/30/2011

Continued on page 16



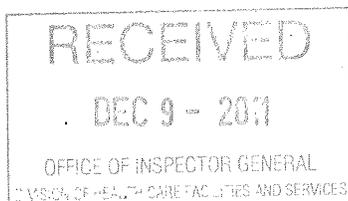
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FILED: 11/21/2011
APPROVED
DATE: 088-0391

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) SURVEY COMPLETED 11/09/2011
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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 40301
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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	<p>Continued From page 15</p> <p>3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>Administrator re-educated and trained the Maintenance Manager on 11/11/2011 regarding the need to replace all latch locks on resident bathroom doors with a push button lock in the door knobs Administrator instructed Maintenance Manager to order these and get them installed as soon as they are received. All resident bathroom doors received these new locks on 11/22/2011.</p>		K 130	<p>4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED AS FOLLOWS:</p> <p>Administrator instructed the Maintenance Manager on 11/11/2011 that if any resident bathroom locks need replacement within the next 12 weeks that Administrator needs to be consulted to ensure that acceptable locks are ordered and installed.</p> <p>This Plan of Correction for Resident Bathroom Lock compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the</p>	



Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

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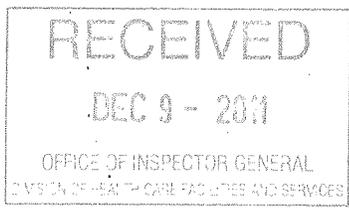
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A - BUILDING: 01 - MAIN BUILDING 01 B - WING: _____
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 40301
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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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K 144	Continued From page 15 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty-five beds and the census was sixty-one (61) on the day of the survey. The findings include: Observation, on 11/09/11 at 2:45 PM, with the Administrator and the Maintenance Director revealed the annunciation panel for the emergency generator, located at the Heritage Hall nurses station, was not functional. Interview, on 11/09/11 at 2:45 PM, with the Administrator and Maintenance Director revealed they were not aware that the annunciation panel did not function. A telephone call to the monitoring company confirmed the observation. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see	K 144	1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No specific residents were cited in the Statement of Deficiency to have been affected; however, on the date of inspection the census was at 61. An outside vendor (VandGuard) corrected the issues with the annunciator panel box on 11/11/2011 and it has been working correctly since this service date. 2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	11/30/2011
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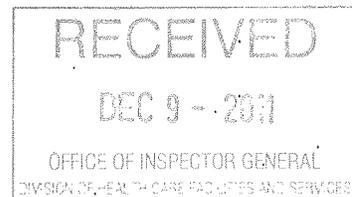
No other residents were identified as having the potential of being affected; however, on the date of inspection the census was at 61..



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	DATE RECEIVED 11/11/2011
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 MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 18 NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144	An outside vendor (VandGuard) corrected the issues with the annunciator panel box on 11/11/2011 and it has been working correctly since this service date. 3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator re-educated and trained the Maintenance Manager on 11/11/2011 regarding the annunciator Continued on page 17A	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147 SS=F NFPA 101 LIFE SAFETY CODE STANDARD Electric Wiring and Equipment	11/30/2011

Continued on page 18



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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 _____	DATE: 09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 40301	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE
K 144	Continued From page 17 panel box and the purpose of it being located at the nursing station. Director of Nursing re-educated and trained licensed nursing staff on 11/28/11 and 11/29/11 of the purpose of the annunciator panel box at the Heritage Hall nursing station and that when the alarm comes on that the Maintenance Manager, Director of Nursing, and Administrator need to be notified immediately because the generator is not running when it needs to be. 4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED AS FOLLOWS: Maintenance Manager will check the annunciator panel box weekly for the next 12 weeks to ensure that it is working correctly. If at		K 144	anytime it is not, issues with it will be corrected immediately. In addition, Maintenance Manger will add this the Preventive Maintenance Schedule for on-going monitoring to ensure this annunciator panel box remains in operation. This Plan of Correction for Annunciator Panel Box compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

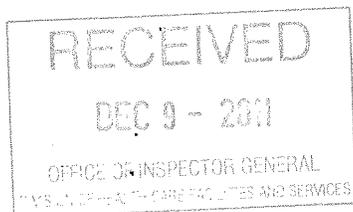
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 11/09/2011
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 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	Continued From page 17 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 according to NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty-five (65) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observations, on 11/09/11 between 12:30 PM and 3:30 PM, with the Administrator and the Director of Maintenance revealed: 1) In Resident Room 26, an extension cord was used to power a television. 2) In Resident Room 24, an extension cord was used to power a portable fan. Two (2) oxygen concentrators were plugged into power strips. 3) In Resident Room 21, an air conditioner, a television, and medical equipment were plugged into a power strip. 4) In Resident Room 22, medical equipment was plugged into a power strip. 5) In the Kitchen, a coffee maker and a meat slicer were plugged into power strips. 6) In the Laundry Room, two (2) pumps for the washing machines were plugged into power strips. 7) In Resident Room 16, an air conditioner was plugged into an extension cord. 8) In Resident Room 14, a bed and a refrigerator were plugged into a power strip. 9) In Resident Room 9, medical equipment	K 147	1) CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Maintenance Manager removed the extension cord that was used to power a television on 11/11/11. Maintenance Manager removed the extension cord that was used to power a portable fan and two oxygen concentrators that were plugged into power strips in Resident Room #24 on 11/11/11. Maintenance Manager corrected all medical equipment, air conditioner, and television that were plugged into a power strip in Resident Room # 21 on 11/11/11. These items are plugged in wall outlets. Maintenance Manager removed the power strip that medical equipment was plugged into in Resident Room # 22 on 11/11/11.	11/30/2011

Maintenance Manager corrected the problems in the kitchen with appliances, commercial coffee maker, and meat slicer being plugged into power strips by removing the power strips on 11/28/2011.

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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 _____	
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 40301	
(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 CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 18 was plugged into a power strip. 10) In the Administration Office, an air conditioner was plugged into a power strip. 11) In the attic space, there were open electrical junction boxes located near the smoke partitions. 12) In the designated smoking area, located outside of the Kitchen, substandard electrical wiring was used to power the disconnect switches for the air compressors.</p> <p>Interviews, on 11/09/11 between 12:30 PM and 3:30 PM, with the Administrator and the Maintenance Director revealed they were not aware of the extension cords and power strips being misused. They were also not aware of the open electrical junction boxes located in the attic space, and the substandard electrical wiring used to power the disconnect switches for the air compressors</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</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>370.28(c) Covers.</p>	K 147	<p>Maintenance Manager corrected the problems in the laundry room with two pumps being plugged into power strips by removing the power strips on 11/28/2011.</p> <p>Maintenance Manager removed the extension cord in Resident Room # 16 where the air conditioner was plugged into on 11/11/11.</p> <p>Maintenance Manager removed the power strip in Resident Room # 14 where the electric bed and resident refrigerator were plugged into a power strip on 11/11/11.</p> <p>Maintenance Manager removed the power strip in Resident Room # 9 where medical equipment was plugged into the power strip on 11/11/11.</p> <p>Maintenance Manager unplugged the air conditioner in the Administrator's office and plugged it into a wall outlet. This work was completed on 11/30/11.</p>	



Maintenance Manager worked with an outside electric vendor to cap the open junction boxes in the attic located near the smoke partitions. This work was completed on 11/29/11.

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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 _____	
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 CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
K 147	Continued From page 19 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.	K 147	Maintenance Manager worked with an outside electric vendor to correct substandard electrical wiring located outside kitchen area. This work was completed on 11/29/11. 2) IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Maintenance Manager completed a 100% audit of all facility resident rooms, facility common areas, and facility offices to ensure that all multi-adaptors that were installed to electric outlets were removed on 11/28/2011. Maintenance Manager completed a 100% of all resident rooms, facility common area and facility offices to ensure that no extension cords were being used on 11/28/2011.	

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Maintenance Manager completed a 100% of all resident rooms, facility common areas and facility offices to ensure that power strips were being used properly, where acceptable for use

Continued on page 20A

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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 11/09/2011
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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

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	DEFICIENCY	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K 147	<p>Continued From page 20</p> <p>Maintenance Manager completed a 100% of all resident rooms to ensure that all medical equipment, electric beds, and resident refrigerators were plugged directly into electric wall outlets, not power strips or extension cords. This was completed on 11/28/2011</p> <p>Maintenance Manager completed a 100% audit of all resident rooms, facility common areas, and facility offices (especially Administrator's Office) to ensure that air conditioners were plugged directly into electric wall outlets, not power strips or extension cords. This was completed on 11/28/2011.</p> <p>Maintenance Manager completed an audit in the facility kitchen to ensure that appliances, commercial coffee pot, and meat slicer were plugged directly into electric outlets, not power strips on 11/28/2011.</p>		K 147	<p>3) MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>Administrator met with the Maintenance Manager on 11/10/11 to provide training to him regarding issues with all medical equipment, electric beds, air conditioners, multi-adaptors, extension cords, power strips, and resident refrigerators. The training consisted of the following: No medical equipment, kitchen appliances, commercial coffee pots, meat slicers, air conditioners, resident refrigerators can be plugged into power strips or multi-wall outlet adaptors. All of these issues must be corrected and that auditing and monitoring for</p>	

FORM CMS-2567(02-09) Previous Versions Obsolete

Event ID: 1FC21

Facility ID: 100101

If continuation sheet Page 20 of 20

All of the above was re-checked by the Administrator on 11/30/2011 and no deficient practices were found. All medical equipment, electric beds, air conditioners, and resident refrigerators were all plugged into electric wall outlets.

compliance for this needs to be as outlined: for the next 4 weeks there will be daily (Monday - Friday) auditing of all resident rooms, offices, kitchen, and other faculty common areas to ensure for compliance of the above.

Continued on page 20B

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OMB NO. 0938-0107

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 11/09/2011
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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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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K 147	<p>Continued From page 20A</p> <p>Any issues found will be immediately corrected, documented, and reported to the Administrator. After this initial auditing, the Maintenance Manager will reduce the auditing to 3 times weekly for the 8 weeks as outlined above.</p> <p>4) FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED, AS FOLLOWS:</p> <p>Maintenance Manager will conduct daily auditing (Monday – Friday) for 4 weeks and then three times weekly for the next 8 weeks to ensure that resident rooms, offices, kitchen, and other common areas in the facility are not using power strips or multi-adaptors improperly.</p>		K 147	<p>Any issues found will be immediately corrected, documented, and reported to the Administrator. In addition, after this 12 weeks of intense monitoring, Maintenance Manager will place this audit on Preventive Maintenance Schedule for weekly auditing.</p> <p>This Plan of Correction for Electric Outlet Plug Compliance monitoring will be integrated into the facility's performance improvement quality system where results will be reviewed and monitored by the Performance Improvement Quality Committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Performance Improvement Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>	

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