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

PRINTED: 02/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING B. WING	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

RECEIVED FEB 2012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on 01/31/12 through 02/02/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of an "E."	F 000	The statements contained in this plan of correction are not an admission and do not constitute agreement with the cited deficiencies. To remain in compliance with federal and state regulations, the center has taken the actions set forth in the following corrections.	
F 253 SS=D	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 and interview, it was determined the facility failed to ensure services necessary to maintain a sanitary and orderly environment. On 02/01/12 at 2:00 PM, two pallets with several cardboard boxes of residents' supplies were observed outside by the door. The supplies remained outside until 02/02/12, after surveyor intervention. The findings include: A review of the job description for the position of Central Supply Clerk, dated November 2004, revealed the supply clerk was to ensure all bio-medical supplies and equipment were properly checked and maintained, in accordance with Federal and State rules and regulations. Additionally, the clerk was to ensure that work assignment areas were clean and equipment,	F 253	F253 1. No resident was directly impacted by the cited deficiency. The shipment was brought indoors and stored properly. 2. The vendor for all products on the cited shipment was contacted and documented that no harm would have come to the products in the environmental conditions in which they were kept. 3. The central supply clerk has been retrained on the proper storage of supplies delivered to the center. All staff were retrained to notify the central supply clerk or the director of nursing if supplies are left outside after hours on 2/28/12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna Davis	Administrator	2/26/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 253	Continued From page 1 tools, supplies, etc. were properly stored before leaving on breaks or at the end of the work day. An observation, on 02/01/12 at 2:00 PM, revealed two wooden pallets of cardboard boxes containing residents' supplies were sitting outside on the ground in the back section of the building. The boxes contained insulin syringes, Glucerna enteral tube feeding, enteral piston syringes, washbasins, band aids, sanitation cloth wipes, gauze sponges, nebulizer masks and tubing, deodorant, hot packs, nasal cannulas for oxygen therapy, lancets for blood sugar testing, antifungal cream, blood sugar test strips, wound cleanser, shave cream, bed pans humidifier packs for oxygen therapy, urinals, urethral catheters, medicine cups, specimen cups, denture cups, drink cups and straws. Further observation, on 02/02/12 at 8:00 AM, revealed the residents' supplies remained outside and the cardboard boxes were damp. An interview with the Central Supply Clerk, on 02/02/12 at 8:00 AM, revealed the residents' supplies were delivered every two weeks and supplies had been delivered on 02/01/12. She stated she usually put the delivered supplies away as soon as they arrived, but she was busy until about 6:30 PM on 02/01/12. She usually stayed over to get everything done and told the Director of Nursing (DON) if she needed help. The Central Supply Clerk did not notify the DON on 02/01/12, "because everyone was already gone" and the residents' supplies were left outside unsecured overnight. An interview with the DON, on 02/02/12 at 8:50	F 253	4. The maintenance supervisor and the housekeeping supervisor will check daily prior to leaving the center to ensure supplies are properly stored. Any variances will be reported to the director of nursing. The Director of nursing will report to the center quality assurance committee monthly for three months to ensure continued compliance.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 253	Continued From page 2 AM, revealed the Central Supply Clerk usually put the delivered supplies away before going home for the day. On 02/01/12, a clerk who worked one day a week to assist was absent on 02/01/12. The DON stated the boxes of resident supplies that were left outside "were not dry."	F 253		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapautic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to complete a comprehensive admission assessment within fourteen (14) days of admission for one resident (#10), in the selected sample of fifteen residents. The findings include: A record review revealed Resident #10 was admitted to the facility on 12/30/11 with diagnoses to include Pneumonia, Sepsis, Systemic Sclerosis and Hyponatremia. He/she was sent to the hospital, on 01/05/12, prior to completion of the comprehensive admission Minimum Data Set (MDS) assessment. He/she returned to the facility on 01/10/12. A comprehensive admission MDS should be completed within fourteen (14)	F 273	F273 1. Resident #10's comprehensive assessment was completed 1/30/12. 2. An audit of all comprehensive admission assessments due in the past 90 days has been completed and no other assessments were found to be out of compliance. 3. The MDS coordinator has been re-inserviced on the requirement to complete a comprehensive assessment within 14 days of admission or readmission on 2/28/12. The interdisciplinary team will discuss all new admissions for the prior day in the morning meeting and on Monday for weekend admissions to ensure the assessment is added to the calendar and completed per regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 273	Continued From page 3 days from re-admission; however, there was no evidence a comprehensive admission MDS was completed. An interview with the MDS Coordinator, on 02/02/12 at 10:15 AM, revealed she had not completed a comprehensive admission MDS for Resident #10. She stated "some sections have been completed, but not in its entirety. It should have been done within 14 days from 01/10/12."	F 273	4. The director of nursing will audit all comprehensive assessments due weekly times four weeks then every two weeks for four weeks then monthly as necessary to ensure compliance. The director of nursing will report findings to the center quality assurance team monthly times 3 months for review and recommendation.	3/9/12
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279	F279 1. A comprehensive care plan related to use of psychoactive medications was completed for resident #5 on 2/1/12. 2. All other residents on psychoactive medications have been reviewed and care plans were found in place for those residents. 3. The MDS coordinator was reinserviced on the center policy for care plans related to psychoactive medications on 2/28/12. The director of nursing and/or unit managers will review all medications daily five days per week and alert the interdisciplinary team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/02/2012
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064	

(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 279	Continued From page 4 Based on record review and staff interview, it was determined the facility failed to develop a comprehensive care plan related to psychoactive medications for one resident (#5), in the selected sample of fifteen residents. The findings include: A record review revealed Resident #5 was admitted to the facility on 04/03/08 with diagnoses to include Dementia, Psychosis, Depression and Chronic Anxiety. A review of the annual Minimum Data Set (MDS), dated 12/24/11, revealed Resident #5 had a Depression Severity Score of sixteen (16), which indicated moderately severe. The resident was nonambulatory, required total assistance of two staff for transfers and toileting, and extensive assistance of one staff for all other activities of daily living. A review of the physician's orders, dated 01/01/12 through 01/31/12, revealed "Pexil (anti-depressant) 20 milligrams (mg) one tablet via tube daily and Seroquel (anti-psychotic) 100 mg one tablet via tube twice daily." Further review revealed no evidence of a care plan for psychoactive medications. An interview with the MDS Coordinator, on 02/01/12 at 2:25 PM, revealed a resident receiving psychoactive medications should have a care plan related to same. After reviewing all care plans for Resident #5, she stated, "the resident does not have a specific care plan related to psychoactive medications. I don't know	F 279	to the need for a psychoactive care plan. 4. The unit managers will audit care plans on all residents on psychoactive medications weekly times 4 weeks then monthly times three months to ensure all care plans are in place. Director of Nursing will report findings monthly to the center quality assurance team for review and recommendation.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 279	Continued From page 5 how that got overlooked." An interview with the Director of Nursing (DON), on 02/02/12 at 9:00 AM, revealed she expected a resident who received psychoactive medications to have a care plan in place. She stated, "The facility does not have a policy related to care plans." She further stated she expected the admitting nurse to initiate an initial care plan upon admission, and the MDS Coordinator, after completion of the MDS assessment, to replace and implement new care plans at that time.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	F280 1. A comprehensive care plan was completed for resident #10 on 1/30/12. 2. All other resident records were reviewed and comprehensive care plans are in place per center policy. 3. The center interdisciplinary team was reinserviced on the timelines and requirements for comprehensive care plans on 2/28/12. The MDS coordinator will produce a calendar of care plan dates for the team and this calendar will be revised as necessary when admissions, transfers or discharges occur. The MDS coordinator shall be responsible for ensuring the comprehensive care plan is completed timely. 4. The Director of nursing will review the records of all residents with comprehensive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 280	Continued From page 6 by: Based on record review and staff interview, it was determined the facility failed to ensure a comprehensive care plan was completed within seven (7) days after completion of the comprehensive admission Minimum Data Set (MDS) assessment for one resident (#10), in the selected sample of fifteen. The findings include: A record review revealed Resident #10 was admitted to the facility on 12/30/11 with diagnoses to include Pneumonia, Sepsis, Systemic Sclerosis and Hyponatremia. He/she was sent out to the hospital on 01/05/12, and re-admitted to the facility on 01/10/12. A review of Resident #10's care plans revealed there were initial care plans to cover the first twenty-one (21) days of admission; however, there was no evidence a comprehensive care plan was developed. An interview with the MDS Coordinator, on 02/02/12 at 10:15 AM, revealed a care plan meeting was conducted on 02/01/12; however, a care plan meeting should have been conducted on 01/30/12. She stated, "the care plan should have been completed twenty-one (21) days following the resident's admission to the facility. I have not had a chance to complete the care plans." An interview the the Director of Nursing (DON), on 02/02/12 at 9:00 AM, revealed she expected the admitting nurse to initiate an initial care plan upon a resident's admission. She further stated she expected the MDS Coordinator, after completion of the MDS assessment, to replace	F 280	care plans due to ensure timeliness weekly times four weeks and monthly times three months. The director of nursing will report findings to the center Quality Assurance committee monthly times three months for review and recommendation.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 280	Continued From page 7 and implement new care plans at that time.	F 280	F281	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality for two residents (#4 and #8), in the selected sample of fifteen residents, related to the failure to accurately assess or monitor bruising, and to ensure physician's orders were followed regarding a dressing change. The findings include: A review of the facility's policy/procedure, "Licensed Nurse Skin/Body Assessments," dated January 2008, revealed the licensed nurse was to assess the residents for any skin irregularities upon admission or re-admission, when alerted by the Certified Nurse Assistants (CNAs) when they identified skin irregularities while rendering care, and when weekly skin assessments were performed. The audits were to be documented on the "Head to Toe Skin Body Assessments" and reported to the skin/wound committee. The licensed nurse was to assess the resident for any irregularities to include bruising, "whether black and blue or fading." At the time of notification, the licensed staff was to notify the resident, physician	F 281	1. Resident #4 was discharged from the center on 2/2/12. Resident #8's physician order was clarified on2/1/12 and a licensed nurse performed an assessment of the suprapubic catheter area with no negative findings. 2. A skin assessment has been completed on all residents and all areas noted have been measured and monitored per center policy. No other residents in the center have suprapubic catheters. 3. All nursing staff were re-inserviced on the center policy for reporting, treating and monitoring skin areas including bruising on 2/28/12. All nursing staff were also re-inserviced on the center policy for dressing changes and for the care of suprapubic catheters on or before 3/9/12. All CNA's were also re-inserviced on their scope of practice as it relates to dressing changes. All dressing changes including those for suprapubic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 281	Continued From page 8 and the responsible party and initiate treatment, assure the skin irregularity is measured, staged and documented in the medical record. 1. A record review revealed Resident #4 was admitted to the facility on 08/12/08 with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's Dementia, Degenerative Arthritis and Chronic Atrial Fibrillation with Anticoagulant Therapy, and a History of Deep Vein Thrombosis (DVT). A review of the "At Risk for Skin Breakdown Related to Decreased Mobility" Care Plan, dated 07/20/10, revealed the resident required weekly skin assessments and all the staff members were to report any signs of skin breakdown. Resident #4 required a Bariatric Mattress with bed bolsters to define the bed borders and to decrease the resident's fear of falling as he/she was being turned/repositioned. A review of the quarterly Minimum Data Set (MDS,) dated 11/25/11, revealed the resident was severely cognitively impaired. Further review revealed he/she had a reduced ability to maintain attention to external stimuli and required the total assistance of two staff members with all aspects of his/her daily care needs. An observation of e skin assessment, completed by Registered Nurse (RN) #1, on 02/01/12 at 10:40 AM, revealed the resident to have numerous bruised areas in varying stages of discoloration. Both elbows were faintly bruised throughout the elbow region with the left elbow having a skin tear measuring four (4) centimeters (cm) by 1.3 cm. An observation of the anterior,	F 281	catheters will be completed by licensed nurses. 4. Skin assessments will be completed on all residents one time per week times four weeks. The Director of Nursing will validate 25% of the skin assessments to ensure all skin areas are being reported and documented appropriately. The Unit Manager will monitor care to the suprapubic catheter five days per week times one week then weekly thereafter. The director of nursing will report findings to the center quality assurance team monthly for review and recommendation.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 281	Continued From page 9 left shoulder area revealed a bluish-black discoloration, measuring 9.05 cm by 5.05 cm, and several dime-sized discolorations on the back of the left shoulder. An interview with CNA #1, on 02/02/12 at 10:40 AM, revealed the CNA stated the resident's bruise to the left shoulder "was not there yesterday." A review of the "Skin Condition Report," completed by RN #1, dated 02/01/12, revealed no measurements of any bruised areas. An interview with RN #1/Unit Manager/Wound Care Nurse, on 02/01/12 at 10:50 AM, revealed Resident #4 had a long history of steroid and anticoagulant therapy, which caused the resident's skin to become "paper thin" and fragile. Additionally, the resident experienced Senile Purpura, which caused increased blood vessel fragility and bruising. He/she also had a history of being fearful with any repositioning in bed and was difficult to turn. Further interview, on 02/02/12 at 12:50 PM, revealed she did not measure or document bruises, only wounds and pressure sores. A review of the "Skin Body Assessment," completed by the licensed staff and dated 01/29/12, revealed there were "ecchymosis noted to the bilateral upper extremities (BUE)" and circled areas noted. A skin assessment was completed, on 01/22/12, and there was no indication of bruising. A review of the nursing notes and condition change forms revealed an entry, on 01/24/12 at 2:00 PM, regarding a skin tear on the posterior left arm above the elbow.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 10 An interview with LPN #1, on 02/02/12 at 2:30 PM, revealed the process for monitoring bruising included weekly skin assessments and CNAs looking at the resident's skin everyday during delivery of care. If a bruise was found or reported, the licensed staff were to assess the bruise and try to determine the origin, measure, document and complete an incident report. The physician and the family were to be notified, as well as the unit manager and the Director of Nursing (DON.) The LPN stated she did not follow the policy for Resident #4's bruising as she did not identify the bruised areas as "true bruises." The LPN stated the resident seemed to have "blood pooling under the skin" moreso than a bruise, and stated the resident's skin became discolored after taking his/her blood pressure due to the pressure of the cuff around his/her arm. An interview with the DON, on 02/01/12 at 4:47 PM, and on 02/02/12 at 2:15 PM, revealed Resident #4 had several issues with the condition of his/her skin. She the staff should follow the policy to assess, measure and monitor the bruises. 2. A record review revealed Resident #8 was admitted to the facility on 04/20/11 with diagnoses to include Acute Renal Failure and Moderate Mental Reterdation. Further review revealed diagnoses to include Urinary Retention and Placement of a Suprapubic Catheter, (a tube inserted into the bladder through an opening in the abdomen in July 2011). A review of the "Functional Urinary Incontinence" care plan, dated 06/21/11, revealed the resident was to be monitored for signs and symptoms of a	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 11 Urinary Tract Infection (UTI) and staff members were to report any absence of elimination, report if the resident had not voided within the shift, and to provide pericare after each incontinent episode. A review of the quarterly MDS, dated 01/20/12, revealed the resident to be cognitively independent, and required limited assistance of one staff with transferring, ambulation and hygiene, and extensive assistance of one staff with toileting. A review of the physician's orders, dated January 2012, revealed to cleanse around the suprapubic catheter with wound cleanser, apply a split Dermafoam ointment, secure with Omnifix tape, change twice daily and as needed. A review of the Medication Administration Records (MARs) and Treatment Administration Records (TARs), dated January 2012, revealed no evidence of an order for a dressing to the suprapubic catheter. A review of the CNA care plan, dated February 2012, revealed the CNAs were to wash the suprapubic catheter site during direct care, and place a Dermafoam dressing on the site to contain exudate. An observation of a dressing change, on 02/01/12 at 2:05 PM, revealed CNA #1 washed around the midline pubic area of the resident's abdomen, the catheter and the tubing with a soapy wash cloth, rinsed with a wet wash cloth and dried the area off. The CNA made a slit into a foam dressing and placed the dressing around the tubing. An interview with CNA #1, on 02/02/12 at 8:30	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12 AM, revealed the dressings were checked by the CNAs "every shift" and if it "looked bad," they were to change them. The CNA stated the catheter had frequent drainage. An Interview with the Certified Medication Aide (CMA) #1, on 02/02/12 at 9:20 AM, revealed the licensed staff completed the dressing changes for Resident #8. She stated the CNAs were not allowed to completer dressing changes and if a Dermafoam dressing needed to be applied to a resident's skin, the CMAs were supposed to do this. An interview with the DON, on 02/01/12 at 2:30 PM, revealed the CNAs were not supposed to be completing dressing changes, but may chenge a "V" shaped dressing while they are changing a resident, if wet or soiled. She was not aware Resident #8 had a dressing change ordered for his/her catheter.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains es free of accident hazards as is possible; and each resident receives adequate supervision and assistance devicas to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to	F 323	F323 1. Resident #3 has not had straws provided at any time since the noted incidence. 2. All other residents with straw restrictions have been reviewed and their tray cards were found to be correct. None were found with straws present.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 323	Continued From page 13 ensure one resident (#3), in the selected sample of fifteen residents, received adequate supervision during a meal. Resident #3 was observed to be utilizing a straw with his/her meal, which was contraindicated. The findings include: A record review revealed Resident #3 was admitted to the facility on 07/02/10 with diagnoses to include Dysphasia, Dementia, Cerebrovascular Accident, Alzheimer's Disease, Depression and Chronic Anxiety. A review of the "Video Fluoroscopic Swallowing Evaluation," dated 08/10/10 at 4:00 PM, revealed Resident #3 had a diagnosis of Mild Oropharyngeal Dysphagia. A modified barium swallow was completed, which revealed Resident #3 did have a cough when he/she drank with a straw. Review of the evaluation revealed to continue with a regular diet and no straw. A review of the physician's order, dated 08/11/10 at 8:45 AM, revealed a diet clarification was received to continue with a regular no added salt diet and no straw. A review of the Nurse Aide Care Plan, undated, revealed Resident #3 was not to have a straw. An observation, on 02/01/12 at 8:05 AM, revealed the resident was in the dining room sitting at the table. A review of the resident's dietary slip revealed he/she was not to have a straw. Resident #3 was being assisted by Certified Restorative Aide (CRA) with his/her milk. The CRA put the straw in the milk carton and	F 323	3. All nursing staff have been re-inserviced on the center policy for following the resident tray card to provide for resident safety on 2/28/12. 4. The Unit Managers will observe meal service on the halls and the Dietary Manager will monitor meal service in the dining room five days per week times two weeks, then one time per week thereafter to ensure the tray cards are being followed. Unit Managers and Dietary Manager will report to the center quality assurance team monthly for review and recommendation.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 323	Continued From page 14 proceeded to assist him/her with the milk. An interview with the CRA, on 02/01/12 at 8:05 AM, revealed that the dietary card read "no straw was to be given to the resident" and it was an over sight on her part. She reported she did not look at the dietary slip. An interview with Charge Nurse #2, on 02/01/12 at 10:10 AM, revealed the resident should not have a straw in his/her milk. She reported he/she was on thickened nectar liquids, and no one with thickened liquids was supposed to use a straw. An interview with the Speech Language Pathologist, on 02/02/12 at 9:50 AM, revealed she evaluated Resident #3 and recommended that no straw be used for drinking. She stated, "the use of a straw propelled the liquid immediately to the back of the throat. Resident #3 had lost muscle coordination in his/her throat and there was an increased risk to aspirate if a straw was used." An interview with the Dietary Manager, on 02/01/12 at 8:15 AM, revealed the resident should not have had a straw in his/her milk.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 1. The dust on the ceiling in the kitchen was removed. All chemicals were removed from the kitchen area and stored properly in the chemical storage room. No specific resident was directly impacted by the failure of the staff to wash their hands. The delivery person was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 371	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy/procedure, it was determined the facility failed to ensure food was prepared, distributed and served under sanitary conditions. A delivery person entered the kitchen tray line area without a hair restraint. Staff were observed to leave the serving line and contaminated their hands and returned to the tray line without washing their hands or re-gloving. A build-up of dust was observed to be hanging from the ceiling. Chemicals were observed stored under the three compartment sink in the kitchen area instead of the chemical closet. The findings include: A review of the facility's policy and procedure, "Hand Washing," (no date), revealed "employees would use proper hand washing techniques to prevent the spread of infection." The procedure section included "all hands were to be washed when entering the dietary department." A policy/procedure related to the use of hair restraints in the kitchen was not provided. Observation during the initial kitchen tour, on 01/31/12 at 9:35 AM, revealed a build-up of dust on the ceiling by the stove hood and the steam table. Two cases of a disinfectant cleaner spray were observed on the shelf under the three compartment sink in the kitchen, instead of the chemical storage room.	F 371	instructed related to hair net usage prior to entering the kitchen area. 2. A full kitchen audit was completed and no other chemicals were found outside the chemical storage. All residents have been assessed with no findings related to the staff not washing hands. 3. A sign has been posted to alert vendors of the center policy on hair restraints. All kitchen staff were re-inserviced on the center policy for handwashing, hair restraints and chemical storage on 02/28/12. Ceiling dusting has been added to the routine cleaning schedule and to the daily sanitation check. 4. The nursing home administrator or maintenance director will check the kitchen five times per week for two weeks to monitor for proper chemical storage. The cook will ensure all vendors are wearing proper hair restraints prior to entering the kitchen area and report any non-compliant vendors to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	186289		02/02/2012

NAME OF PROVIDER OR SUPPLIER: CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 201 WATSON STREET, MARION, KY 42064

(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 371	Continued From page 16 Observation during the noon meal service, on 01/31/12 at 11:15 AM, revealed the cook and two kitchen staff were plating food to residents' trays. During the tray preparation the cook left the steam table, retrieved lettuce and tomatoes from a refrigerator, made a sandwich for a resident, and returned to plating food without washing her hands or re-gloving. The cook left the steam table a second time and retrieved food items from the refrigerator, then returned to plating food from the steam table without washing her hands or re-gloving. Kitchen staff #1 and #2, who were assisting to assemble resident food trays, were observed to stop assembling food trays and touch items contaminating their hands and return to assembling food trays. Kitchen staff #2 was observed, on 01/31/12 at 11:50 AM, to stop food tray preparation, obtain a carton of thickener and return to assembling food trays without washing her hands or gloving. Kitchen staff #1 was observed, on 01/31/12 at 11:51 AM, to stop assembling food trays and to answer the telephone and then return to assembling food trays without washing her hands or gloving. On 01/31/12 at 11:50 AM, a delivery person was observed to enter the kitchen and passed by the steam table where kitchen staff were plating food on the residents' trays without a hair restraint or washing his hands. The delivery person then unloaded cases of milk into the milk cooler. An interview with the Dietary Manager, on 01/31/12 at 12:00 PM, revealed the kitchen staff should have washed their hands and re-gloved when they stopped assembling food trays to	F 371	center administrator. The Dietary Manager will perform a sanitation audit weekly times four weeks and monthly thereafter to monitor compliance. The dietary manager will monitor the tray line five times per week times two weeks and weekly thereafter to ensure proper handwashing is occurring. All findings will be reported to the center quality assurance team monthly for review and recommendation.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 371	Continued From page 17 retrieve items and answer the phone, before returning to finish assembling food trays. She revealed the disinfectant cleaner spray was not supposed to be in the kitchen area, but should have been in a locked place and the delivery person should have worn a hair restraint before entering the kitchen area. The Dietary Manager revealed there was no policy related to the use of hair restraints in the kitchen area. Additionally, she stated she could not recall when the ceiling area was last cleaned. Maintenance usually cleaned or painted the ceiling.	F 371		

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

PRINTED: 02/16/2012
FORM APPROVED
OMB NO. 0938-0391

RECEIVED MAR 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1961, 1979 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V (111) SMOKE COMPARTMENTS: Eight (8) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system GENERATOR: Type II generator, fuel source is diesel. A standard Life Safety Code survey was conducted on 01/31/12. Crittenden County Health and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred five (105) beds and the census was seventy four (74) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	K018 The hinged wooden gates on resident rooms #308, 310, 316, 408, 413, 510, 601, and 618 to prevent wandering residents from entering these rooms have been removed. All resident room doors were inspected to ensure that nothing was impeding the door closing and tie backs have been installed to ensure resident privacy curtains do not get caught in doors. All staff will be inserviced by the administrator or director of nursing prior to 3/9/12 on the use of the tie backs and the regulation that the doors not be impeded. The maintenance director was inserviced on the regulation on 2/28/12. No further gates will be installed on resident room doors. The administrator and maintenance director will make center rounds weekly to ensure no doors are impeded. Any issues related to gates or doors will be brought to the center quality assurance team monthly for review and recommendation.	3/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/7/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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		
	Deficiencies were cited with the highest deficiency identified at "F" level.			
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		
	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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 Roller latches are prohibited by CMS regulations in all health care facilities.			
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in corridors were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred five (105) beds with a census of seventy four (74)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 2 on the day of the survey. The findings include: Observation, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the facility had installed hinged wooden gates on resident room #308, 310, 316, 408, 413, 510, 601, and 618 to prevent wandering residents from entering these rooms. Further observation revealed the gates when closed impede access to the room door to enable closure during a fire. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the facility had placed the gates on the resident room doorframes due to residents wandering into other resident rooms. Reference: NFPA 101 (2000 Edition). 19.3.6.3 Corridor Doors. 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 13/4-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	K 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 similar 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 5 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.	K 018		
K 025 SS=F	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	K 025	K025 All smoke partitions extending above the ceiling located throughout the facility that were noted to have penetrations by wires or piping have had the spaces around the penetrations were filled with a fire rated material equal to the rating of the partitions such as fire rated caulking.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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	Continued From page 4 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 in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred five (105) beds with a census of seventy four (74) on the day of the survey. The findings include: Observation, on 01/31/12 between 1:00 PM end 5:00 PM, with the Maintenance Director revealed the smoke partitions extending above the ceiling located throughout the facility, were noted to have penetrations by wires, or piping. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware of the penetrations. Reference: NFPA 101 (2000 Edition).	K 025	The maintenance director completed a audit of all smoke barriers in the center and all identified penetrations have been sealed. The maintenance director was reinserviced on the regulation regarding penetrations to smoke barriers on 2/28/12 by the administrator. The center maintenance director will make monthly rounds to inspect the smoke barriers to ensure that any new penetrations have been sealed with material equal to the rating of the smoke barrier. The maintenance director will report findings to the center quality assurance team monthly times three months for review and recommendation.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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	Continued From page 5 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027	K 027 The cross-corridor doors located between the 200 and 300 Hall have been repaired and now close completely when tested, leaving a gap of less than 1/8 of an inch between the pair of doors and will resist the passage of smoke.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 027	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross -corridor doors located in a smoke barrier would resist the passage of smoke. These doors must close all the way and be smoke tight to help prevent smoke from reaching other parts of the building in the event of an emergency. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred five (105) beds with a census of seventy four (74) on the days of the survey. The findings include: Observation, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the cross-corridor doors located between the 200, and 300 Hall, would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed they were unaware the doors would not close all the way leaving a gap between the doors in the closed position and acknowledged the doors would not resist the passage of smoke in the event of an emergency. Reference: NFPA 101 (2000 edition)	K 027	All cross corridor doors were tested and no other doors were found to have gaps greater than 1/8". The maintenance director was inserviced on the regulation that no gaps larger than 1/8" were allowed on 2/28/12 by the administrator. All cross-corridor doors will be tested weekly by the maintenance director to ensure no improper gaps exist. Findings will be reported monthly to the quality assurance team for review and recommendation.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 027	Continued From page 7 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027		
K 056 SS=D	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, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred five (105) beds with a census of seventy four (74) on the day of the survey. The findings include:	K 056	K056 The two porches that extend out four feet or greater, made of combustible materials will have sprinklers installed. The two porches are located outside the exits at each end of the 600 Hall. A sprinkler will also be installed in the basement to cover the hallway area. A full audit of the center has been completed and no other areas were identified to be in need of additional sprinklers. The maintenance director was re-inserviced on the regulation for sprinkler coverage on 2/28/12. The maintenance director will make rounds weekly to ensure that adequate sprinkler coverage exists. The maintenance director will report findings to the center quality assurance committee monthly times three months to ensure continued compliance.	4/1/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 056	Continued From page 8 Observation, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed two (2) porches to extend out four (4) foot or greater, made of combustible materials, and were not sprinkler protected. The two (2) porches are located outside the exits at each end of the 600 Hall. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed they were not aware the porches needed to be sprinkler protected. Observation, on 01/31/12 at 1:40 PM, with the Maintenance Director revealed the Hallway in the basement did not have adequate sprinkler coverage to spray around the corner. Interview, on 01/31/12 at 1:40 PM, with the Maintenance Director revealed he had never noticed the lack of coverage but confirmed the coverage was not adequate. 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.	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 062	Continued From page 9 continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred five (105) beds with a census of seventy four (74) on the day of the survey. The findings include: Observation, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed sprinkler heads located throughout the facility to be covered in lint. Further observation revealed insulation stuck to the sprinkler heads located in the attic above the 500 Hall. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware of the lint build up, or the insulation on the sprinkler heads. Observation, and record review, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the facility had STAR sprinkler heads located in several parts of the facility that could be part of a recall. The	K 062	K062 All sprinkler heads throughout the center have been dusted and a routine maintenance plan has been established to ensure the sprinklers stay dust free. The insulation found on the sprinklers in the attic area has been removed and these areas will be checked weekly. All sprinkler heads in the facility have been inspected to identify any Star sprinklers that were a part of the recall and it was determined that the sprinklers on Hall 200, 300, 400, Lobby, partial nurses station and partial dining area and kitchen are affected. These pendants will be replaced. An interior pipe inspection will be completed and will be added to the center's preventive maintenance schedule. The maintenance director has been re-inserviced on the requirement for the sprinkler pendants to remain dust free and uncovered on 2/28/12 by the center administrator. The maintenance director will conduct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 062	Continued From page 10 facility failed to produce evidence that the sprinkler heads had been checked to confirm if the Star sprinkler heads in the facility were part of the recall. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware of the recall and did not know if the heads had been checked. Record review, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the facility had not performed an interior pipe inspection on the sprinkler system since it was installed in 1969. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware the sprinkler system was required to have an internal pipe inspection to check for obstructions in the pipe. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical	K 062	weekly inspections of the sprinkler head pendants. Any inspection findings will be reviewed by the center quality assurance team monthly time three months for review and recommendation.	4/30/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/31/2012
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064	

(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 062	Continued From page 11 damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for	K 062		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/31/2012
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064	

(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 062	Continued From page 12 obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by exemining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.	K 062		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred five (105) beds with a census of seventy four (74) on the day of the survey.	K 070	K070 All portable heating devices have been removed from the center. A full facility inspection was conducted and no additional portable heating devices were found. The maintenance director was re-inserviced on 2/28/12 on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 070	Continued From page 13 The findings include: Observation, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed portable space heaters located in the Administrators Office, MDS Office, and the Smoking Shack. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed they were aware the heaters were not permitted in patient care areas, but not aware the heating element could not exceed, 212°F (100°C) when used in non-sleeping staff and employee areas. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	regulation regarding use of portable space heaters in the center. The Maintenance director will make visual inspection monthly to ensure no additional devices are brought in. Any issues related to supplemental heating will be brought to the center quality assurance team monthly for review and recommendation.	3/9/12
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	K072 All items have been removed from hallways and no means of egress is impeded. All exit hallways in the center have been inspected and alternate locations found for all items when not in use. Carts, wheelchairs, lifts and other items	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/31/2012
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 14 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred five (105) beds with a census of seventy four (74) on the day of the survey. The findings include: Observation, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed soiled linen carts, lifts, wheelchairs, and clean linen carts were being stored in the 400, and 500 Halls. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the facility routinely stored linen carts, lifts, wheelchairs, and clean linen carts in these halls. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	are stored off the hallways at all times when not in use. These items will be stored in empty resident rooms and unused shower rooms. The maintenance director was re-inserviced on the regulation for unimpeded hallways and exits by the center administrator on 2/28/12. Maintenance director will inspect hallways daily to ensure that this standard is met. The maintenance director will report findings to the center quality assurance team monthly times three months for review and recommendation.	3/9/12
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/31/2012
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064	

(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 130	Continued From page 15 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. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred five (105) beds, with a census of seventy four (74) on the day of the survey. The findings include: Observation, on 01/31/12 at 3:13 PM, with the Maintenance Director revealed an unapproved lock (slide bolt type) was installed on the egress side of the Dietary Storage Exit. Interview, on 01/31/12 at 3:13 PM, with the Maintenance Director revealed they were aware of the lock, but not aware they were prohibited. Observation, on 01/31/12 at 1:50 PM, with the Maintenance Director revealed heavy lint build up in the top, burner area of the dryer located in the Laundry Room. Interview, on 01/31/12 at 1:50 PM, with the Maintenance Director revealed the Maintenance Staff was responsible for cleaning the top of the dryer, but confirmed the lint accumulated in the top of the dryer was significant. 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.	K 130	K130 The unapproved slide bolt lock was removed from the dietary storage exit. No additional slide type locks will be added to any egress doors. All doors in the center were checked and no additional slide type locks were identified. The dryer lint build up in the top burner area of the dryer in the laundry room has been removed. All center dryers were checked and cleaned of lint. A weekly cleaning schedule has been established by the center maintenance director to ensure that the dryer top stays free of lint buildup. The maintenance director was re-inserviced on 2/28/12 on the regulations for egress doors and	
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185269		01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	201 WATSON STREET MARION, KY 42064

(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 SS=E	Continued From page 16 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred five (105) beds with a census of seventy four (74) on the day of the survey. The findings include: Observations, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed: 1) Soap dispensing pumps to the washing machines in the Laundry Room were plugged into a power strip. 2) Storage in front of electrical panels located in the Laundry Room. 3) An extension cord in use located in the Dining Room. 4) An extension cord was in use and plugged into a power strip located in the Director of Food Services Office. 5) An extension cord was plugged into a power strip located in the Social Services Office. 6) An extension cord was in use in the Human Resources Office, Administrators Office, Director	K 147	for prevention of lint buildup in dryers. The administrator will make weekly rounds in the laundry to ensure continued compliance and will reports any findings to the quality assurance team monthly for review and recommendation. K147 The soap dispensing pumps in the laundry are no longer plugged into a power strip. Items blocking the electrical panel in the laundry room have been relocated. The extension cords in the Dining Room, the Dietary Office, the Social Service Office, the Human	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING	01/31/2012

NAME OF PROVIDER OR SUPPLIER
CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
201 WATSON STREET
MARION, KY 42064

(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 of Nursing Office, and the Business Office. 7) A bed and an air mattress pump were plugged into a multi-plug adaptor located in room #417. 8) An extension cord was in use located in room #419. 9) A bed, mini nebulizer, and an extension cord were plugged into a power strip located in room #402. 10) A power strip was plugged into an extension cord located in room #405. 11) A wheelchair charger was plugged into a power strip located in room #405. 12) A bed and an oxygen concentrator were plugged into a power strip located in room #413. 13) An extension cord in use located in room #507. 14) A power strip was plugged into another power strip located in the MDS Office. 15) Open electrical junction boxes were located in the attic above the 400 Hall and the 600 Hall. Interview, on 01/31/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware the extension cords were only for temporary use, or the power strips were being misused. He was also not aware of the storage in front of the electrical panels, or the open junction boxes in the attic. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D	K 147	Resources office, the Administrator Office, the Director of Nursing Office and the Business office have all been removed. The multi-plug adapter in room 417 has been removed. The power strips and the extension cords in room 402 and 405 have been removed. The power strip has been removed from room 413. The extension cord has been removed from room 507. The power strip is no longer plugged into a power strip in the MDS office. The open electrical junction boxes in the attics have been replaced and covered. A full inspection of the center was completed and all other extension cords were removed. The maintenance director was re-inserviced on 2/28/12 on the regulation governing extension cord use in the laundry and throughout the center. The laundry staff were re-inserviced on the center policy for the electrical panel boxes not to be blocked on 3/6/12 by the maintenance director. The maintenance director will make weekly full- center rounds	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. BUILDING 01 - BUILDING B. WING	01/31/2012

NAME OF PROVIDER OR SUPPLIER: CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 201 WATSON STREET, MARION, KY 42064

(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 18 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. 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. Reference: NFPA 70 (1999 edition) 370.28(c) Covers. 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	to ensure no additional extension cords are in use. The maintenance director will check the panel boxes daily to ensure compliance. The maintenance director will report monthly times three to the center quality assurance team monthly for review and recommendation.	3/13/12