

PRINTED: 01/05/2012
FORM APPROVED
OMB 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: 185150	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/16/2011
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NAME OF PROVIDER OR SUPPLIER KNOTT COUNTY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822
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F 000	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 12/14-16/11. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>An abbreviated standard survey (KY17119, KY17313) was also conducted at this time. KY17119 was substantiated with no deficient practice identified. KY17313 was unsubstantiated with no deficient practice identified.</p> <p>F 253 SS=E 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observations throughout the facility revealed soiled baseboards, soiled doors, doors with splintered edges, soiled toilet seats, a chipped lavatory, and a wheelchair in need of repair.</p> <p>The findings include: According to the facility's Administrator on 12/16/11, at 11:30 A.M., the facility did not have a policy related to maintenance/housekeeping needs of the facility.</p>	F 000	<p>1. All items and areas in need of repair have been repaired. The rough splintered doors in room 109-123-124-151-158 & 159 have been sanded. Baseboards in room 103-106-107-109-115-116-117-118-120-121-122-124-151-156-158-159 & 168 have all been vigorously cleaned. Doors in rooms 117-121-123-126-158-159 & 168 have all been cleaned and replaced with vinyl protectors. The chipped lavatory edge in room 168 has been repaired with caulking and sanded with no sharp edges. Toilet seats/bowels in room 114 & 123 were cleaned and sanitized with no stains detected. W/C in room 171-2 has been replaced with a new side panel and the w/c in room 105-2 has been replaced with a new arm rest.</p> <p>2. All resident rooms and entire facility are all safe and functional. A very thorough environmental tour has been conducted throughout the facility and all identified concerns have been corrected immediately.</p> <p>3. On January 4, 2012 a mandatory in-service was conducted with all staff including Housekeeping and Maintenance by the Administrator and all areas of concern were specifically addressed as well as the CQI process and Maintenance notification. Also stressed to Housekeeping and Maintenance the importance of observing for items in need of repair and report and repair in a timely manner.</p> <p>4. CQI Committee Designee will conduct thorough rounds on a weekly basis for one month, then monthly for one quarter to observe for items in need of repair or replaced or areas in need of extra cleaning. Any problems will be corrected immediately and reported to the CQI Committee for further follow up and review. Housekeeping will also include baseboards on the monthly clean down schedule.</p> <p>5. Completion Date: January 13, 2012.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ruby A. Piggman</i>	TITLE Administrator	(X6) DATE 1-13-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Jan. 13. 2012 10:34AM No. 4681

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F 253	<p>Continued From page 1</p> <p>Observations of the facility from 12/14/11 through 12/16/11, revealed the following areas were in need of maintenance/housekeeping services:</p> <ol style="list-style-type: none"> 1. Rough, splintered doors were observed in resident rooms 109, 123, 124, 151, 158, and 159. 2. Baseboards in resident rooms 103, 106, 107, 109, 115, 116, 117, 118, 120, 121, 122, 124, 151, 156, 158, 159, and 168 were observed to have a heavy buildup of dust and dirt. 3. Doors in resident rooms 105, 117, 121, 123, 126, 158, 159, and 168 were observed to have a heavy buildup of soil. 4. Toilet seats/bowls in resident rooms 114 and 123 were observed to be soiled and/or stained. 5. A chipped lavatory edge was observed in resident room 168. 6. The wheelchair in resident room 171-2 was observed to have a loose side panel and the wheelchair in resident room 105-2 was observed to have a torn/worn armrest with the cover missing. <p>An interview with the Housekeeping Supervisor and the Maintenance Supervisor during the environmental tour on 12/16/11, revealed staff was to submit work requests for repairs needed in resident rooms. Both supervisors stated they made observations of resident rooms on a regular basis, but were unaware of these housekeeping/maintenance needs.</p>	F 253		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY	F 372		

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F 372	<p>Continued From page 2</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to ensure that garbage and refuse were disposed of properly. Observation of the containment area for garbage/refuse on 12/14/11, at 1:00 PM, revealed the metal dumpster was full of garbage and refuse. In addition, twenty-five garbage bags filled with garbage and refuse were observed to be stored on the dumpster lid preventing complete closure of the lid. The twenty-five bags of trash were accessible to insects, rodents, and other wildlife. Observation also revealed the metal dumpster containing the garbage and refuse was placed partially on an absorbent soil surface and, as a result, could not easily be cleansed to prevent the spills from absorbing into the surrounding soil and was not easily washed.</p> <p>The findings include:</p> <p>An interview conducted with the facility Administrator on 12/16/11, at 9:35 AM, revealed, the facility did not have a policy on trash/refuse containment/disposal.</p> <p>Observation of the facility dumpster on 12/14/11, at 1:00 PM, revealed the facility trash dumpster was filled with garbage/refuse that prevented a tight fitting closure of the dumpster lids on all four sides. Further observation of the dumpster revealed 25 trash bags filled with garbage/refuse had been placed on top of the lids allowing</p>	F 372	<ol style="list-style-type: none"> Our contracted waste management company was contacted immediately to empty garbage dumpster and the surrounding area were cleaned. Arrangements were made for our contractor to provide two dumpsters instead of one and to pick up garbage five days a week (Monday through Friday). A concrete pad has been installed for the dumpsters to sit on therefore preventing any contamination of contents absorbing into the ground. Housckeping and Dietary staff have been in-serviced by the Administrator on December 14, 2012 to stress the importance of all garbage being confined entirely in the dumpster with nothing being on top of the dumpster lid. The lid must be closed completely after garbage is disposed into them. Additional education and in-service was conducted on January 4, 2012 by the Administrator with Housckeping, Maintenance and Dietary Departments with proper procedure and disposal of garbage and plan for two dumpsters instead of one with them now being placed on a concrete surface. A CQI Committee member designee will monitor the waste receptacles to ensure that all garbage is completely confined in dumpster receptacles with lids closed. The designee will monitor the dumpster once a day for two weeks then weekly for one month, then monthly for the next quarter. Any irregularities noted will be corrected immediately and reported to CQI committee for further review. Completion Date: January 13, 2012. 	
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F 372	<p>Continued From page 3</p> <p>exposure to insects, rodents and other wildlife. In addition, the metal dumpster was placed partially on a soil surface preventing the easy cleaning of grease/shortening and other liquid spills/leaks from the dumpster. One of the trash bags was observed to have a milky white liquid dripping from the side of the trash bag onto a nonwashable soil surface. The milky white substance was draining downhill to the facility parking lot and grassy area surrounding the building on the 100 side of the building.</p> <p>An interview was conducted with Certified Nursing Assistant (CNA) #1 on 12/14/11, at 1:00 PM. The CNA stated the soiled resident briefs and other soiled resident items were also disposed in the dumpster containment system. The CNA further stated facility staff was unable to dispose of all of the garbage/waste from the facility into the dumpster each day because the dumpster was not large enough to contain all the facility trash/waste.</p> <p>An interview was conducted with CNA #2 on 12/14/11, at 2:02 PM. CNA #2 stated the trash bags contained soiled resident briefs and other soiled resident items. CNA #2 further stated the trash was picked up on a daily basis, Monday through Friday, by the local trash collector.</p> <p>An interview was conducted with the facility Dietary Manager on 12/14/11, at 2:10 PM. The Dietary Manager (DM) stated the garbage was collected on a daily basis Monday through Friday. The DM further stated the garbage/refuse was not collected on Saturday/Sunday.</p> <p>An interview conducted with the facility</p>	F 372			

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F 372	Continued From page 4 Administrator on 12/14/11, at 3:25 PM, revealed the facility had attempted for an extra day of trash collection on the weekend but had been unable to obtain the extra day of pickup. The facility Administrator acknowledged bears, raccoons, and other wildlife had been observed in the local community.	F 372		
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. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	1. Resident #3 is receiving care, including skin assessments by staff that are utilizing appropriate hand-washing techniques. Ice pass is occurring for all residents following proper infection control techniques. The ice scoops were discarded and the ice scoops, coolers and machines were immediately cleaned and sanitized. All medication carts were cleaned and the sticky powdery substance removed. 2. All nurses are providing care with appropriate hand-washing techniques being observed. All residents are receiving ice pass by staff that are following acceptable infection control techniques. All medication carts are clean, sanitary and organized. 3. All nursing staff were in-serviced by the Administrator on January 4, 2012 on proper technique on infection control practices relating to appropriate hand-washing and glove changing during care and skin assessments, ice pass and medication cart cleanliness. Specific instructions included hand washing/glove changing during skin assessments, not allowing the ice scoop handle to come into contact with the ice and the scoop being placed in the appropriate holder when not in use.	

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F 441	<p>Continued From page 5 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, and a review of facility policies, the facility failed to ensure an infection control program was maintained to provide a safe, sanitary, and comfortable environment. Observations revealed staff failed to wash hands their hands as indicated when they provided personal care to residents. Staff was also observed to pass ice to residents and to place the ice scoop on the cart and/or in the ice bin. In addition, medication carts throughout the facility were observed to have sticky residue and powdery debris inside the drawers.</p> <p>The findings include:</p> <p>1. A review of the Infection Control Policy revealed staff was directed to perform appropriate hand hygiene to prevent health care related infection and spread of multi-resistant organisms. Staff was directed to wash hands or use an alcohol-based rub for decontaminating hands when moving from a contaminated body site to a clean body site during care.</p> <p>Observation on 12/15/11, at 2:45 PM, of Licensed Practical Nurse (LPN) #3 performing a skin</p>	F 441	<p>4. All nurses will be observed and checked off by the CQI designee for proper infection control during care and skin assessments. These observations will be done with four nurses per week (or until all nurses have been observed) for one month. Then four nurses will be chosen at random to be observed monthly for one quarter. Ice pass to residents will be monitored by CQI Designee to ensure proper infection control practices are being followed. The ice pass monitoring will be five times per week on various shifts for one month and then weekly for one month. Medication carts will be cleaned once a week. Carts will be monitored by CQI Committee designee weekly for one month and then monthly. Any irregularities will be corrected immediately and reported to the CQI committee for further review.</p> <p>5. Completion Date: January 13, 2012.</p>	
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F 441	<p>Continued From page 6</p> <p>assessment of Resident #3 revealed that LPN #3 failed to wash her hands and apply new gloves after assessing Resident #3's perineum and after wiping cream off of Resident #3's bottom. LPN #3 continued performing the skin assessment touching Resident #3's back, oxygen tubing, face, ears, and hair.</p> <p>LPN #3 acknowledged in interview on 12/15/11, at 4:04 PM, that she should have washed her hands and changed her gloves when she cleansed the resident's buttock area and before assessment of the resident's perineum.</p> <p>2. A review of the Ice Pass Policy/Procedure revealed staff was to replace the ice scoop in the proper place at the ice machine and to replace the scoop in the proper covered holder on the ice cart to prevent contamination. The staff was further directed not to leave the ice scoop in the ice.</p> <p>Observation of the ice pass on 12/14/11, at 1:00 PM, revealed staff obtained ice from an ice cart with an ice scoop and placed the ice scoop, uncovered, on the exposed shelf of the ice cart instead of the scoop holder on the cart. In addition, observation of the ice machine on the 100 Unit revealed a large ice scoop had been placed in the ice machine and the handle was in direct contact with the ice.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1 on 12/14/11, at 3:25 PM, revealed the SRNA was aware the ice scoop should have been placed in the holder. The SRNA further stated she did not know who had left the scoop in the ice rather than the holder.</p>	F 441			

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F 441	<p>Continued From page 7</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 12/14/11, at 3:35 PM, revealed the LPN was responsible to supervise the SRNAs to ensure they delivered care/services with correct techniques, however, LPN #1 stated she had not observed the ice pass on 12/14/11.</p> <p>An interview with the Infection Control Nurse on 12/14/11, at 3:30 PM, revealed staff was to follow correct infection control technique when they delivered ice to residents.</p> <p>3. The facility's Infection Control Policy included "environmental factors may facilitate transmission of infections among residents such as equipment used to provide care."</p> <p>Observations of three medication carts on 12/16/11, revealed all three carts contained a sticky residue inside the drawers where liquid medications were stored. A powdery residue was also observed inside the medication drawers used to store medications in tablet/pill form.</p> <p>An interview with LPN #4 on 12/16/11, at 3:00 PM, revealed there was no policy or schedule for cleaning the medication carts. According to LPN #4, LPNs were to clean up spills of medications but no one was responsible to clean the cart on a routine basis.</p>	F 441		
F 468 SS=E	<p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly secured handrails on each side.</p>	F 468		

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F 468	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure handrails in corridors were firmly secured. On 12/14/11, the handrails adjacent to resident rooms 124, 125, 126, 101, 105, 111, 114, 155, 171, 161, and 174 were loose from the wall. In addition the handrails in the corridor adjacent to the women's shower room, the Physician's Office, the supply room, adjacent to and across from the dining room on the 100 Unit, and adjacent to the Exit door on the 200 Unit were observed to be loose and not firmly attached to the wall. The findings include: According to the facility Administrator, the facility did not have a policy related to maintenance of handrails. Observations during a facility tour on 12/14/11, revealed the handrails adjacent to resident rooms 124, 125, 126, 101, 105, 111, 114, 155, 171, 161, and 174 were loose and not firmly attached to the wall. In addition, the handrails in the corridor adjacent to the women's shower room, the Physician's Office, the therapy room, the supply room, adjacent to and across from the dining room on the 100 Unit, and adjacent to the Exit door on the 200 Unit were observed to be loose from the wall. An interview with the Maintenance Supervisor on 12/14/11, at 3:20 PM, revealed he attempts to monitor the handrails on a monthly basis and was unaware of the loose handrails.	F 468	1. All handrails adjacent to rooms 124-125-126-101-105-111-114-155-171-161 & 174 were immediately firmly secured to the wall by Maintenance Supervisor in addition to all other handrails throughout the facility were checked and if needed were firmly secured to the wall. 2. All handrails throughout the facility were also checked to ensure that they were secured to the wall. Handrails throughout the facility are safe and functional for use. Any identified concerns corrected immediately. 3. On January 4, 2012 a mandatory in-service was conducted by the Administrator for all facility staff and reinforced the importance of reporting loose handrails to maintenance for immediate repair and the correct CQI process on reporting problems found. 4. CQI committee Designee will conduct a thorough inspection daily for one month then monthly for one quarter. Any identified problem will correct immediately and reported to CQI Committee for further review. 5. Completion Date: January 13, 2012.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		

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F 514	<p>Continued From page 9 LE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility protocols, the facility failed to maintain accurate clinical record information related to the code (resuscitative) status for two of nineteen sampled residents (Residents #1 and #6). A review of physician's orders in the medical record of Resident #1 revealed the physician had requested the resident's resuscitation status to be "Do Not Resuscitate" (withhold lifesaving care), however, the "alert" in the front of the chart was "Full Code" (In the event of cardiac/respiratory failure, a person's wishes that every possible measure available would be used to resuscitate them). Resident #6's code status was listed as "Do Not Resuscitate" but the physician's orders were for "Full Code."</p> <p>The findings include: A review of the Protocol for Obtaining Code</p>	F 514	<p>1. Resident #1's code status was clarified by the resident and responsible party. The condition alert sheet was then changed to state DNR to match all corresponding documents. Resident #6's code status was clarified by resident and responsible party and was consistent with the DNR sheet signed. A new physician's order was then obtained to set his code status to a DNR per resident and responsible party's wishes.</p> <p>2. All residents' charts were reviewed for accuracy of code status by the Unit Supervisors. The signed code status was compared to the physician's orders, the condition alert sheet and the care plan to ensure consistency of all resident records. If any discrepancies found, the responsible party, resident and the physician were contacted for clarification. After review of all records, all were documented accurately and consistently.</p> <p>3. An in-service was held on January 4, 2012 by the Administrator with all nursing staff regarding the procedure for obtaining and documenting a code status. Specifics of in-service included: documentation of a code status. An order is to be written for each code status obtained, a signed consent by resident/responsible party and the physician, the code status will be placed on the Condition Alert sheet and then the code status will be placed on residents care plan. Each month the Unit Supervisor will compare the signed code status sheet to the physician's orders and to the Condition Alert sheet for accuracy. All new admissions and readmissions will have a code status obtained and placed on a consent sheet, the Condition Alert sheet and a Physicians order written. If resident or responsible party wants to make changes to a code status, the same process will apply. The nurse completing the admission, readmission or a request for change is being made will be responsible for completing the paperwork.</p>	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185150	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/18/2011
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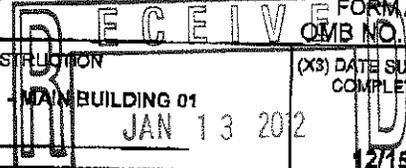
NAME OF PROVIDER OR SUPPLIER KNOTT COUNTY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822
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F 514	<p>Continued From page 10</p> <p>Status Consent revealed the Admission Coordinator/designee was to obtain a signed Do Not Resuscitate/Cardio Pulmonary Resuscitation (DNR/CPR) consent form upon admission to the facility. The nurse responsible for admitting the resident was then responsible for contacting the physician for telephone orders regarding code status.</p> <p>1. A review of the medical record for Resident #1 revealed the resident's family member/responsible party had signed the DNR/CPR consent on 10/10/10 to confirm the resident's DNR status. The physician's orders for Resident #1 also confirmed the resident with DNR status. However the "Alert Sheet" on the front of the chart had a large sticker to indicate the Resident had Full Code status.</p> <p>2. A review of Resident #6's medical record revealed this resident's DNR/CPR consent form had been signed on 08/11/11, to indicate the resident had DNR status and the Alert Sheet on the front of the chart had a large DNR sticker on it; however, the physician's orders indicated the resident was to be a Full Code status.</p> <p>An interview with Registered Nurse (RN) #1 on 12/15/11, at 2:15 PM, revealed she was responsible to check physician's orders every month for accuracy. RN #1 stated she checked the previous month's orders, the Medexes, the treatment records, and telephone orders to ensure accuracy and had missed the physician's order for Full Code status for Resident #6, and corrected the Alert Sheet for Resident #1 on the day of the interview.</p>	F 514	<p>4. The CQI Committee Designee will conduct chart audits to ensure accuracy of code status. The committee designee will conduct the audits by choosing at random five charts from each unit per week for one month then monthly for one quarter. These audits will include reviews of all new admits and re-admits. Any concerns will be addressed immediately and reviewed by the CQI committee.</p> <p>5. Completion Date: January 13, 2012.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185150	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/15/2011
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NAME OF PROVIDER OR SUPPLIER KNOTT COUNTY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN RD of Health Care HINDMAN KY 40322 Southern Enforcement Branch
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1978 Survey under: NFPA 101 (2000 Edition) Chapter 19 (existing health care) Facility type: SNF/NF Type of structure: Type II (222) Smoke Compartment: 5 Fire Alarm: Complete fire alarm with smoke detectors in corridors and resident rooms Sprinkler System: Complete automatic sprinkler system Generator: Type II, Diesel, installed 2008 A standard Life Safety Code survey was conducted on 12/15/11. Knott County Health and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 91. The facility is licensed for 82 beds. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire).	K 000		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Christy A. Pigman* TITLE Administrator (X6) DATE 1-13-12

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.

Received Time Jan. 13. 2012 10:34AM No. 4681

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NAME OF PROVIDER OR SUPPLIER KNOTT COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 386 PERKINS MADDEN ROAD HINDMAN, KY 41022	
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K 072	<p>Continued From page 1</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of five smoke compartments, twenty-five residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 12/15/11, at 2:33 PM, revealed the outside exit leading from the dining room area was blocked by various objects that prevented instant use of the exit in the event of a fire or other emergency. The objects included tables, chairs, and a tent with awning. Exits must be kept free and clear of objects to allow for instant use during a fire or other emergency. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 12/15/11, at 2:33 PM, with the Maintenance Director, revealed the objects would be removed from the exit. Further interview revealed the objects had been there for approximately one year.</p>	K 072	<ol style="list-style-type: none"> The outside exit leading off from the dining room was immediately cleared of table's, chairs, tent and furniture. A thorough inspection of the entire building was completed. All furniture, objects and furnishings have been removed from exit area to allow for a clear uncluttered path to the outside. No other areas noted as a concern. No residents have been affected. All staff in-serviced on January 4, 2012 by the Administrator to keep all exits free of clutter, furniture or any object that could block or impede an exit to the outside. Reviewed with Maintenance and Housekeeping staff the regulation regarding: blocking exits. CQI Designee will do a walking round five times a week for one month then weekly thereafter. Any concerns identified will be corrected immediately. Completion Date: January 13, 2012. 	

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K 072	Continued From page 2 Reference: NFPA 101 (2000 Edition). 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		
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