

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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A recertification survey was conducted on August 6-8, 2013 with deficiencies cited at the highest scope and severity at an "E". The facility had the opportunity to correct the deficiencies before imposition of remedies would be recommended. A Life Safety Code survey was conducted on 08/06/13 with no deficiencies cited.	F 000	This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide appropriate housekeeping and maintenance services related to two (2) shower rooms on two (2) halls, Lincoln Lane and Heritage Hall. The facility failed to ensure shower rooms were clean, free of debris, personal care items were stored appropriately and faucets were in good repair.  The findings include:  Review of the facility's Shower Room Cleaning Policy and Procedure, not dated, revealed the facility considered cleanliness of shower rooms as a means to prevent the spread of infection. The purpose of the shower room cleaning was for the health and safety of residents. Housekeeping staff was responsible for cleaning the shower rooms towards the end of first shift daily. Nursing	F 253	F253 SS=E Environment 483.15 (h)(2) Shower Room Presentation  No specific residents were cited in the statement of deficiency as having been affected; however, the first day of survey the census was at 62.  The housekeeping staff deep cleaned both the Heritage Hall and Lincoln Lane Resident Shower Rooms on 8/15/2013.  Maintenance Manager checked commodes, sinks, and faucets in both the Heritage Hall and Lincoln Lane Resident Shower Rooms and made necessary repairs on 8/12/2013.  No other residents were identified as having the potential to be affected; however, first day of survey the census was at 62.  All problem areas identified by the survey were addressed by nursing staff,	Completion Date: 9/1/2013	

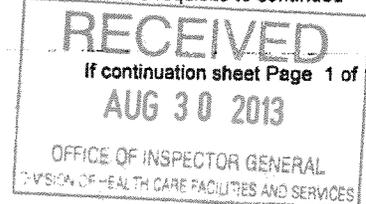
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*X [Signature]*

TITLE  
*X Administrator*

(X8) DATE  
*X 8/30/13*

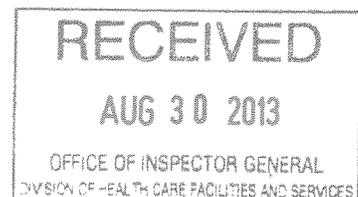
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

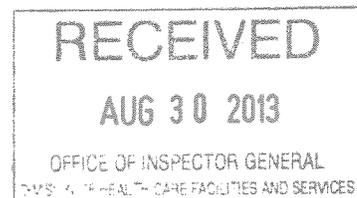
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	<p>Continued From page 1</p> <p>staff was responsible for cleaning the shower room after each resident shower. These responsibilities included disinfecting the shower chairs and placing any trash/dirty linens in the proper containers. Before taking a resident into the shower room, nursing was responsible for inspecting the shower room to ensure the cleanliness of the shower room.</p> <p>Observation of the Heritage Hall shower room, on initial tour, on 07/30/13 at 9:20 AM, revealed the shower room floor tile to have a thick build up brown substance between the tile and along the wall edges. Dirty linen carts and trash carts were stored in the shower room, and 1 bottle of drinking water was stored on top of the dirty trash cart. The sink in the shower room was dripping water, and a dirty glove was lying in the shower stall. A sign on the back of the shower room door, read remove all soiled items, PC (personal care) items, and trash from shower room after use. Routine inspections are completed daily.</p> <p>Further observation of the Lincoln Lane Shower Room, on initial tour, on 07/30/13 at 9:00 AM, revealed a bag of dirty linens lying on the shower chair, a bag of trash lying in the floor, with shaving cream and lotions sitting in an unlocked cabinet. A bottle of shampoo was sitting in the floor of the shower room, and dirty paper towels were piled in the sink. There was water around the base of the commode, with dirty paper towels and toilet tissue lying in the water.</p> <p>Interview with the Housekeeper, on 08/06/24 at 2:52 PM, revealed he was responsible for cleaning the showers; however, stated it should be cleaned after each shower, or before the next shower. The Housekeeper stated he cleaned the</p>	F 253	<p>housekeeping staff and maintenance manager to ensure that resident shower rooms were in compliance with this regulation by 8/30/2013.</p> <p><b>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</b></p> <p>Administrator provided education and training to all department managers on 8/21/2013 regarding the regulation tag F253 to define environment, the intent of the regulation, definition of orderly, guidelines for preventing spread of infection, what resident care equipment consisted of, how to complete a resident shower room assessment and what questions to ask yourself, gave examples of a shower room being in compliance with regulations and example of shower room not in compliance with regulations, identify the problems with the shower rooms during survey dates, revised a shower room presentation policy and procedure that better outlined responsibilities for nursing, housekeeping and maintenance staff, and educated to this policy and procedure.</p> <p>Department Managers who supervise staff and the Staff Education/Training Nurse provided the education for regulation tag F253 as outlined above to all other staff. This was completed by 8/30/2013.</p>		



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	<p>Continued From page 2</p> <p>showers daily between 1:30-2:00 PM, and the Nursing Assistants were responsible for cleaning and picking up after each shower.</p> <p>Interview with the Heritage Hall LPN #2, on 08/08/13 at 2:45 PM, revealed Nurses on the 3-11 and 11-7 shifts should monitor shower rooms and Nursing Assistants who give the showers. The nurse stated there should not be dirty linens or trash bags lying in the shower rooms, nor should there be any trash lying in the floor. The Nurse stated she was not aware of any leaking faucets in the shower room.</p> <p>Interview with Lincoln Hall LPN #1, on 08/08/13 at 2:50 PM, revealed there were showers completed on the 3-11 shift, nurses were responsible to monitor the shower room, and Nursing Assistants were responsible to clean up after each shower. The nurse stated there should not be any debris, trash in the room, and was not aware of any leaking water in the room, until the initial tour with the surveyor, on 08/06/13. In addition, LPN #1 revealed there had probably not been a shower given since the evening before the initial tour.</p> <p>Interview with the Administrator, on 08/08/13 at 1:00 PM, revealed the outside doors were locked to both shower rooms, and stated she did not think it was not a problem that shampoos were left in the unlocked cabinets. The Administrator stated the Nursing Department was responsible for monitoring the shower rooms, and Housekeeping would have cleaned the previous day around 2:30-3:00 PM; however, the 2nd shift would have given showers, and would be expected to clean the shower room after each use. The Administrator stated she was not aware of any work orders for leaking faucet or toilets.</p>	F 253	<p>In addition all staff were required to take a competency test regarding this regulation and had to score at least 90%. This was all completed by 8/30/2013.</p> <p><b>The following monitoring has been put into place to ensure for compliance with this regulation in relation to resident shower rooms:</b></p> <p>Effective 8/19/2013, Housekeeping staff will check the two resident shower rooms first thing each morning when starting their work day and will clean them as necessary. Housekeeping staff will continue to do their complete daily cleaning of the two resident shower rooms towards the end of first shift. Housekeeping staff will document the two shower rooms' cleanings on their daily cleaning logs.</p> <p>Housekeeping staff will start deep cleaning the two resident shower rooms weekly instead of monthly. This change started for the week of 8/18/2013 and will be an on-going practice. Housekeeping staff will document the two shower rooms' deep cleans on their cleaning logs, effective for the week of 8/18/2013.</p> <p>Effective for the week of 8/18/2013, Housekeeping Manager will check the two shower rooms 5 xs weekly to ensure that they are clean, orderly, and in proper repair</p> <p>Continued on Page 3A</p>		



Continuation from Page 3 --- F253

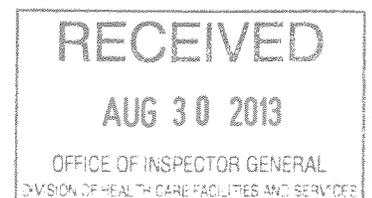
for resident use for the next 3 months. Monitoring will then be reduced to 3 xs weekly for the next 9 months or until the next annual survey; whichever comes first.

On 8/23/2013, Maintenance Manager started doing a weekly inspection of the two resident shower rooms to ensure that all maintenance issues are addressed timely. This will be an on-going weekly task that will be documented for the next 12 months or until the next annual survey; whichever comes first.

Nursing staff are to ensure they clean up the shower room after each resident use as is outlined in the Shower Room Policy and Procedure. The two shower rooms will be checked by an assigned nursing staff at the beginning and ending of each shift and this will be documented on the shower room log. When there are issues identified with the two shower rooms, the charge nurse is responsible for ensuring the shower rooms are cleaned and ready for the next resident and will be required to document action taken on the shower room log. This will be effective starting 8/26/2013. This will be an on-going practice as outlined in the Shower Room Policy and Procedure.

Continued on Page 3B

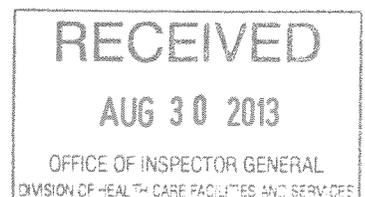
Page 3A



Continuation from Page 3A --- F253

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly for the next 3 months (September 2013 – November 2013) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality committee will determine at that time to either continue monthly monitoring or to reduce monitoring to quarterly for the next 9 months (December 2013 – August 2014) or until the next annual survey; whichever comes first. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, staff education & training nurse, business office manager, social service director, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

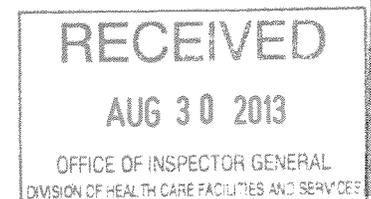
Page 3B



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

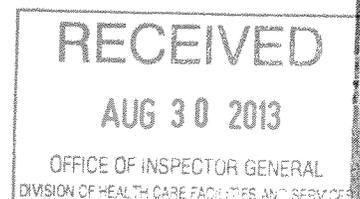
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to implement care plan approaches regarding indwelling catheter care for one (1) of fifteen (15) sampled residents. The facility failed to provide evidence that physician ordered catheter care was provided to Resident #5 as care planned.</p> <p>The findings include:</p> <p>The facility did not provide a policy on care plan implementation.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident on 07/09/13 with a diagnoses of Diabetes, Hypotension, Altered Mental Status, and Urinary Tract Infection (UTI). Review of the Admission Assessment, dated 07/17/13, revealed the facility assessed the resident to be frequently incontinent of bowel and bladder. On 07/26/13, the resident was transferred to a local hospital for lethargy, productive cough, and abnormal lung sounds. The hospital admitted the resident with Pneumonia and Dehydration. On 07/31/13, the resident was re-admitted to the nursing facility with an indwelling catheter. Review of the hospital discharge orders dated 07/31/13 revealed the catheter was to be discontinued in one week. On</p>	F 282	<p>F282 Completion Date: 9/1/2013 SS= D 483.20(k)(3)(ii) Services By Qualified Persons/ Per Care Plan</p> <p>Resident #5 was the only resident cited in the statement of deficiency as having been affected.</p> <p>On 8/9/13 order was received from MD to remove Resident #5's indwelling catheter and check for Post Residual Volume. Resident #5 indwelling catheter care --- Plan of Care was discontinued at that time.</p> <p>There were 4 other Residents in the facility with indwelling catheters that were identified as having potential to be affected; and on the first day of survey census was at 62.</p> <p>The Director of Nursing completed 100% audit of all other Residents with indwelling catheters to ensure that residents care plans were being followed according to MD orders. This audit was completed and any corrections needed made on 8/12/13. Then for the remaining residents --- 100% audit of all resident care plans was completed by the Director of Nursing &amp; Assistant Director of Nursing to determine other residents that could be potentially affected by this deficient practice. This audit and all corrections needed were completed by 8/30/13.</p> <p>The measures that were put into place or systemic changes made to ensure that this</p>	



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

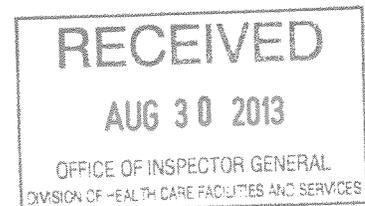
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 4</p> <p>08/02/13, the resident's primary physician ordered catheter care every shift.</p> <p>Observation of Resident #5, on 08/06/13 at 11:30 AM, revealed the resident laying in bed asleep. An indwelling catheter to a bedside drainage bag was observed to be anchored to the bed frame. Observations on 8/07/13 at 8:15 AM, 9:57 AM, 11:05 AM, 11:35 AM, 12:40 PM, and 1:55 PM revealed the resident lying in bed with the indwelling catheter in place. Observation, on 08/08/13 at 9:05 AM, revealed the indwelling catheter remained. No catheter care was observed. Interview with Resident #1 revealed the resident was unable to voice if catheter care had been provided.</p> <p>Review of the care plan, revised 08/02/13, revealed catheter care was to be performed every shift and as needed. Review of the Treatment Administration Record (TAR) and search of the clinical record revealed no documented evidence the catheter care had been provided.</p> <p>Interview with LPN #1, on 08/08/13 at 1:45 PM, revealed she was working the day the resident's primary physician visited (08/02/13) and took off the order for catheter care every shift. She stated she failed to transcribe the order onto the TAR; therefore, there was no evidence the catheter care had been provided. She stated the nurses were responsible for performing catheter care and it appeared nobody had noticed the scheduled catheter care was not on the TAR. She stated she had completed catheter care but failed to document. She did not know about the other nurses.</p> <p>Interview with the Director of Nursing, on</p>	F 282	<p><b>deficient practice does not recur included the following:</b></p> <p>The Director of Nursing, Assistant Director of Nursing, or Staff Development RN completed re-educate for all licensed nurses on: 1.) Assessing residents to ensure that they have proper diagnosis for all treatments and medications; 2.) That all treatments and medications are to be written on the medication treatment records (MARS) and/or treatment administration records (TARS). This education was completed by 8/30/13. Also a competency test was given immediately after re-education and training to verify licensed nursing staff competency. (All had to made 90% or above on the competency test).</p> <p>In conjunction with ensuring care plans are fully developed, the Director of Nursing, Assistant</p> <p>Director of Nursing, Staff Development RN, and/or MDS Coordinator will develop written comprehensive care plans within 7 days after completion of the resident comprehensive assessment. This became effective for 8/9/2013.</p> <p><b>The following monitoring has been put into place to ensure for compliance with this regulation:</b></p>		



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 08/08/13 at approximately 3:40 PM, revealed she was not aware the resident's indwelling catheter had not been discontinued and catheter care had not been documented as completed. She stated the nurse had failed to transcribe the order onto the TAR, therefore, no documentation of completion. She could not say if the care had been given.	F 282	Director of Nursing, Assistant Director or Nursing, Unit Manager, and/or Staff Development RN will review 5 Resident care plans every week for 12 weeks and then will audit 10 resident care plans monthly for  Continued on Page 6A	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure residents without a indwelling catheter were not catheterized unless a clinical condition demonstrated the need for an indwelling catheter for one (1) of fifteen (15) sampled residents. The facility failed to reassess Resident #5 upon readmission with an indwelling catheter and failed to remove the catheter after a physician ordered it to be removed in one week.  The findings include:	F 315	F-315 SS=D 483.25(d) No Catheter, Prevent UTI, Restore Bladder  Resident #5 was the only resident cited in the statement of deficiency as having been affected.  Order was received on 8/9/13 for Resident #5 to have indwelling catheter removed and to check post residual volume. Resident #5 indwelling catheter was removed 8/9/2013.  There were 4 other Residents in the facility with indwelling catheters that were identified as having potential to be affected; and on the first day of survey census was at 62.  On 8/12/2013, Director of Nursing reassessed the 4 other residents who were identified as having an indwelling catheter to ensure that their clinical condition warranted the use of the indwelling catheter. All residents with an indwelling catheter were found to have appropriate diagnosis and clinical condition to warrant the use of the indwelling catheter. Continued on Page 7	Completion Date: 9/1/2013

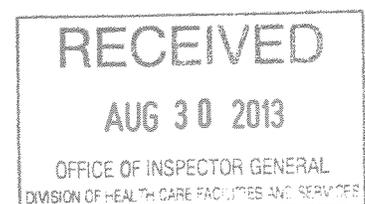


Continuation from Page 6 --- F282

9 months to ensure that care plans are being followed according to the resident clinical condition or MD orders. This auditing will start the week of 9/2/13.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly for the next 3 months (September 2013 – November 2013) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality committee will determine at that time to either continue monthly monitoring or to reduce monitoring to quarterly for the next 9 months (December 2013 – August 2014) or until the next annual survey; whichever comes first. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, staff education & training nurse, business office manager, social service director, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

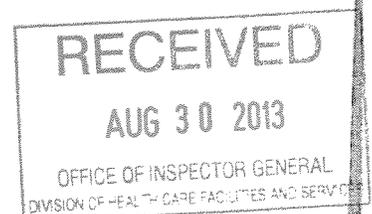
Page 6A



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

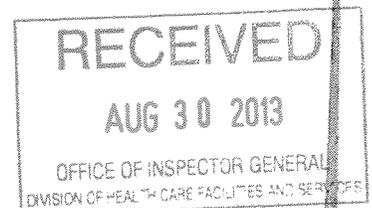
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	<p>Continued From page 6</p> <p>Review of the facility's policy titled Catheter Care, Urinary, revised October 2010, revealed catheter care procedure was to prevent catheter associated urinary tract infections (UTI). The policy detailed how to provide catheter care and to document in the medical record the date and time catheter care was given with signature and title of the person recording the data.</p> <p>The facility did not provide a policy regarding clinical conditions that would demonstrate necessity of the indwelling catheter or supporting diagnoses.</p> <p>Observation of Resident #5, on 08/06/13 at 11:30 AM, revealed the resident laying in bed asleep. An indwelling catheter to a bedside drainage bag was observed to be anchored to the bed frame. At 4:34 PM, the drainage bag was observed to be lying on the floor. Observation on 8/07/13 at 8:15 AM and 9:57 AM, revealed the drainage bag touching the floor. Continued observation at 11:05 AM, 11:35 AM, 12:40 PM, and 1:55 PM revealed the resident lying in bed with the indwelling catheter in place. Observation, on 08/08/13 at 9:05 AM, revealed the indwelling catheter remained.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident on 07/09/13 with a diagnosis of UTI. Review of the admission nursing assessment and initial Minimum Data Set (MDS) assessment, dated 7/17/13, revealed the facility assessed the resident to be frequently incontinent of bowel and bladder. Review of the comprehensive care plan dated 07/11/13 revealed an intervention under the impaired skin integrity for incontinent care as needed, adult briefs, and barrier cream to be</p>	F 315	<p>Continuation from Page 6</p> <p><b>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</b></p> <p>Director of Nursing, Assistant Director of Nursing and/or Staff Development RN re-educated all licensed nursing staff 1.) indwelling catheter is not used unless there is medical justification 2.) indwelling catheter for which continuing use is not medically justified must be discontinued as soon as clinically warranted 3.) services are provided to restore or improve normal bladder function after the removal of the catheter 4.) any resident with or without a catheter receives the appropriate care and services to prevent infections. A competency test was given after re-education to determine competency. (All licensed nursing staff were required to score a 90% or higher.) This was all completed by 8/30/2013.</p> <p><b>The following monitoring has been put into place to ensure for compliance with this regulation:</b></p> <p>Effective for 8/12/2013, Director of Nursing, Assistant Director of Nursing, Staff Development RN, MDS Coordinator, and/or Unit Manager will monitor every admission, readmission, and any resident within the facility with a new order for an indwelling</p>	



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

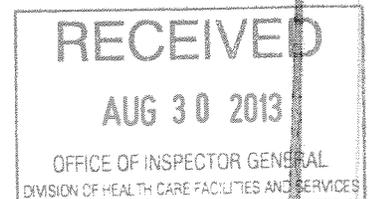
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 7 applied as indicated. Review of the AccuNurse (computer program) documentation, from July 9-26, 2013, revealed urine incontinent care was provided.  Continued review of the clinical record revealed on 07/26/13, the resident was transferred to a local hospital for lethargy, productive cough, and abnormal lung sounds. The hospital admitted the resident with Pneumonia and Dehydration. On 07/31/13, the resident was re-admitted to the nursing facility with an indwelling catheter that had been inserted at the hospital. Review of the hospital discharge orders dated 07/31/13 revealed the catheter was to be discontinued in one week. On 08/02/13, the resident's primary physician confirmed the order to discontinue the catheter in one week and to perform catheter care every shift. Review of the care plan revised 08/02/13 revealed catheter care was to be performed every shift and as needed. Search of the clinical record revealed no supporting diagnoses or clinical condition to support the use of the indwelling catheter. The hospital discharge diagnoses were Metabolic Encephalopathy, UTI resolved, Diabetes, Severe Dysphagia requiring tube feeding, Osteoporosis, Hypertension, and Osteoarthritis.  Review of the Treatment Administration Record (TAR) for Resident #5 revealed the order to discontinue the indwelling catheter and provide catheter care every shift had not been transcribe onto the August TAR. In addition, there was no documentation of any catheter care in the clinical record.  Interview with LPN #1, on 08/08/13 at 1:45 PM, revealed she had been the nurse who took off the	F 315	catheter to ensure that the resident has appropriate diagnosis or clinical condition to warrant the use of the indwelling catheter for the next 12 months or until the next annual survey; whichever comes first.  This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly for the next 3 months (September 2013 – November 2013) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality committee will determine at that time to either continue monthly monitoring or to reduce monitoring to quarterly for the next 9 months (December 2013 – August 2014) or until the next annual survey; whichever comes first. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, staff education & training nurse, business office manager, social service director, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.		



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 8 re-admission orders on 07/31/13 to discontinue the indwelling catheter in one week. In addition, she worked the day the primary physician visited Resident #5 (08/02/13) and ordered catheter care every shift. She stated she failed to transcribe the order onto the TAR; therefore, the catheter had not been discontinued in one week as ordered by the physician. In addition, she acknowledged she failed to place the order to provide catheter care every shift onto the TAR. She stated she had provided catheter care; however, she did not document that task in the clinical record or onto the TAR.  Interview with the Director of Nursing, on 08/08/13 at approximately 3:40 PM, revealed she was not aware the resident's indwelling catheter had not been discontinued. She stated most catheters are discontinued immediately upon re-admission unless the resident had a supporting diagnosis or clinical condition that warranted the catheter placement. She reviewed the clinical record and stated the hospital physician had documented the resident had Functional Quadriplegia. However, she acknowledged the resident could move all extremities and was incontinent of bowel and bladder prior to hospitalization where the catheter was inserted. She reviewed the clinical record and stated there was no documented evidence catheter care had been provided. She later returned and reported that the resident's primary physician gave an order to discontinue the indwelling catheter today and check for residue.	F 315			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an	F 441	F-441 SS=D 483.65 Infection Control, Prevent Spread, Linens	Completion Date: 9/1/2013	



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441 Continued From page 9  
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 professional practice.

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

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

F 441 Resident #5 was the only resident cited in the statement of deficiency as having been affected.

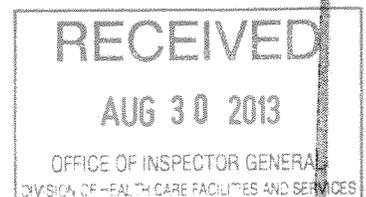
Employee #1 LPN was re-educated on 8/23/2013 by Director of Nursing on infection control practices, especially emphasizing proper hand hygiene to prevent the spread of infection and wound care treatment.

During the annual survey of 8/6/13 – 8/8/13, the surveyors watched wound care being performed on all residents having wounds. Only employee #1 LPN was found to have issues with following wound care protocol.

Employee #1 LPN was re-educated on 8/23/2013 by Director of Nursing on infection control practices, especially emphasizing proper hand hygiene to prevent the spread of infection and wound care treatment.

The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:

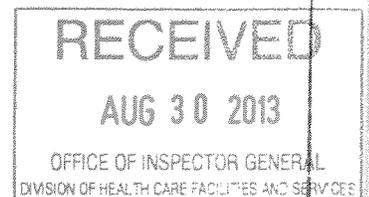
Director of Nursing, Assistant Director of Nursing, Staff Development RN, and/or Unit Manager re-educated all licensed nurses on 1.) process of handling, storing and transporting linens to prevent the spread of infection; 2.) requirement of hand washing after direct resident contact; 3.) prohibiting employees with communicable



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

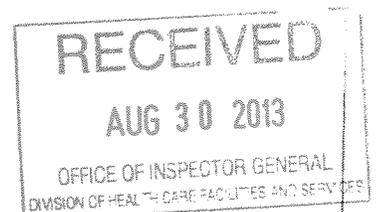
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 10</p> <p>the facility's policy, it was determined the facility failed to consistently implement their infection control policy regarding hand hygiene to prevent transmission of disease and infection during a wound dressing for one (1) of fifteen (15) sampled residents. Resident #5.</p> <p>The findings include:</p> <p>Review of the handwashing/hand hygiene policy, (revision date of June 2010) revealed hand hygiene was the primary means to prevent the spread of infection. Hands should be washed after removal of gloves and before and after changing a dressing.</p> <p>Review of the CDC guidelines, revealed gloves should be changed: when soiled (e.g., with blood, or other body fluids); and when going from a dirty area or task to a clean area or task. The CDC defined a dirty area as an area where there was a potential for contamination with blood or body fluids and areas where contaminated or used supplies, equipment, blood supplies or biohazard containers are stored or handled. A clean area was an area designated only for clean and unused equipment and supplies and medications; when moving from a contaminated body site to a clean body site of the same patient; and after touching one patient or their machine and before arriving to care for another patient or touch another patient's machine. According to the CDC, even with glove use, hand hygiene was necessary after glove removal because hands could become contaminated through small defects in the gloves and from the outer surface of the gloves during glove removal.</p>	F 441	<p>disease or infected skin lesions from direct contact with residents or food ;4.) when a resident needs isolation to prevent the spread of infection, the facility will isolate the resident; and 5.) explaining the purpose of the infection control program---to investigate, control, and prevent infections; to isolate residents as determined appropriate; and to maintain a record of incidents and corrective actions related to infections. A competency test was given and completed by 8/30/2013 after re-education to ensure competency with all licensed nursing staff. (All licensed nursing staff were required to score 90% or above on the competency test). The education was completed on 8/30/13. All licensed staff members were observed while completing wound care treatment and head to toe skin assessments. This was all completed by 8/30/13.</p> <p>The Staff Development RN will ensure that when completing orientation for newly employed nursing staff, that they are aware of their responsibilities outlined above as part of their orientation training and competency testing. This is effective starting 8-31-13.</p> <p><b>The following monitoring has been put into place to ensure for compliance with this regulation:</b></p> <p>Director of Nursing, Assistant Director of Nursing, Staff Development RN, and/or Unit Manager will observe 5 head to toe skin assessments and wound care dressing</p>	



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

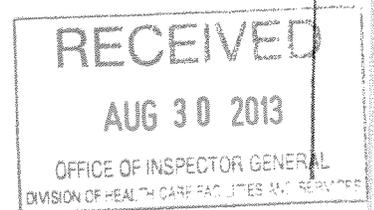
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 11</p> <p>Observation of a skin assessment and a wound care treatment, on 08/07/13 at 11:15 AM, with LPN #1 revealed a head to toe skin assessment was conducted after the nurse (LPN #1) applied clean gloves. After the skin assessment, the nurse proceeded to complete the wound treatment with the same gloves she had used to touch the resident's entire body including the perineal area. After removal of the soiled dressing, the nurse changed her gloves, but did not wash her hands. She applied clean gloves and continued with the wound treatment. In addition, when the nurse went to apply the Sea Sorb dressing to the resident's wound bed, she dropped the dressing onto the bed sheet, picked the dressing up, and applied it to the wound bed. She then removed her gloves and washed her hands.</p> <p>Interview with LPN #1, on 08/08/13 at 1:45 PM, revealed she should have changed her gloves and washed her hands after completing the skin assessment. She thought she could use the same gloves after the skin assessment to remove the soiled dressing because they were not soiled. However, she had touched the perineal area. In addition, she stated you are supposed to wash your hands after removal of gloves. She stated when she dropped the Sea Sorb dressing onto the bed, she should have disposed of that dressing and obtained another dressing.</p> <p>Review of the clinical record revealed the facility admitted Resident #5 on 07/09/13 with history of an infection and a pressure ulcer on the middle spine.</p> <p>Review of the training records revealed LPN #1 had received inservice on infection control and</p>	F 441	<p>changes every week for 2 weeks (starting week of 9/2/2013), then will observe 5 head to toe skin assessments and wound care dressing changes for the next 11 months or until the next annual survey; whichever comes first.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly for the next 3 months (September 2013 – November 2013) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality committee will determine at that time to either continue monthly monitoring or to reduce monitoring to quarterly for the next 9 months (December 2013 – August 2014) or until the next annual survey; whichever comes first. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, staff education &amp; training nurse, business office manager, social service director, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>		



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

PRINTED: 08/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 bloodborne pathogens on 06/12/13.	F 441		



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

PRINTED: 09/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELIZABETHTOWN NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 WOODLAND DRIVE</b> <b>ELIZABETHTOWN, KY 42701</b>		
(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  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/01/13 as alleged.	{F 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 10/04/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELIZABETHTOWN NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet (anti-freeze) sprinkler system.</p> <p>GENERATOR: Type II, 13 KW generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 08/06/13. Elizabethtown Nursing and Rehabilitation Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.