

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

PRINTED: 08/12/2014
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 07/31/2014
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 07/29/14 and concluded on 07/31/14 with deficiencies cited at the highest scope and severity of an "F".

F 253 483.15(h)(2) HOUSEKEEPING & SS=E 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 maintain a clean environment for five (5) bathrooms on Lincoln Lane and seven (7) bathrooms on Heritage Hall that had a brown-yellow substance staining the floor tiles and no caulking around the bases of the toilets; in addition, bathrooms in rooms #5, #16, #26 and #34 had a persistent strong urine odor on 07/29/14 and 07/30/14.

The finding include:

No policy was provided by the facility regarding Housekeeping.

Observations of the resident's environment on Lincoln Lane, on 07/30/14 at 9:35 AM, revealed rooms #21, #23, #29, #30 and #34 had a yellow-brown substance on the floor tiles surrounding the toilets with no caulking around the base of the toilets.

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

F253 Completion Date: 8/26/2014
SS=E
Environment 483.15 (h)(2) Housekeeping & Maintenance Services

The specific residents that were cited in the statement of deficiency as having been affected were as follows: 1) Resident bathrooms #2, #3, #5, #6, #11, #12, #16, #21, #23, #29, #30, and #34 for a brown substance on floor tiles surrounding the toilets with no caulking around the base of toilets; 2) Resident bathrooms #5, #16, and #26 with a smell of urine; 3) Resident bathrooms #26, and #34 with a black build-up on the floor and baseboards.

The housekeeping staff deep cleaned all of the cited resident bathrooms by 8/22/2014 that included cleaning up the brown substance on floors, sweeping, mopping, and sanitizing floors to eliminate urine odors, and removing and cleaning up the black substance build-up on the floor and baseboards.

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

TITLE

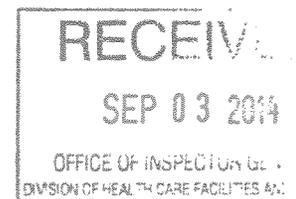
(X8) DATE

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.

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F 253	<p>Continued From page 1</p> <p>Observations of the resident's environment on Heritage Hall, on 07/30/14 at 9:50 AM, revealed rooms #2, #3, #5, #6, #11, #12 and #16 had a yellow-brown substance on the floor tiles surrounding the toilets with no caulking around the base of the toilets.</p> <p>Observations of rooms #5 and #16, on 07/29/14 at 1:30 PM, revealed the bathrooms had a strong smell of urine. Further observations of rooms #5 and #16, on 07/30/14 at 9:50 AM, revealed rooms #5 and #16 continued to have a strong smell of urine.</p> <p>Observation, on 07/29/14 at 9:07 AM, revealed Room #26's bathroom had a black buildup on the floor and baseboards. Observation also revealed a black substance on the edges at the base of the toilet and a strong odor of urine.</p> <p>Observation, on 7/29/14 at 9:15 AM, revealed Room #34's bathroom had a brownish-black substance around the edges of the base of the toilet. Observation also revealed a black substance on the grout of the wall tiles.</p> <p>Interview with Housekeeper #1, on 07/30/14 at 10:00 AM, revealed there was a daily room sheet that was checked when the task was completed in each room. Housekeeper #1 stated she had noticed the brown-yellow substance on the base of the commodes and could not clean it up. She stated she deep cleaned every room once a month.</p> <p>Review of the Heritage Hall Deep Cleaning Room List, revealed all rooms had been deep cleaned for the month of July.</p>	F 253	<p>Maintenance Manager removed old caulk from all of the cited resident bathrooms around the basin of the commodes and replaced with new caulking by 8/22/2014.</p> <p>Administrator audited the results of the housekeeping staffs work and the maintenance managers work to ensure compliance with this regulation on 8/22/2014.</p> <p>Housekeeping/Laundry Supervisor did an audit on 8/15/2014 of the remaining seven resident bathrooms, which included the following: #1, #8, #13, #18, #20, #22, and #36.</p> <p>All problem areas identified through this audit were corrected by housekeeping staff by 8/22/2014 to be in compliance with this regulation.</p> <p>Administrator audited the results of the housekeeping staffs work on 8/22/2014 to ensure the work was in compliance with this regulation.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>Administrator provided education and training to the maintenance manager and the housekeeping/laundry supervisor on</p>	



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F 253 Continued From page 2

Continued interview, on 07/30/14, with Housekeeper #1, revealed she informed her supervisor about the condition of the floor tiles and toilets; however, had not heard anything back. Housekeeper #1 stated the toilets look like they needed to be cleaned. Housekeeper #1 stated Maintenance was responsible for the caulking around the base of the toilets.

Interview with the Housekeeping Manager, on 07/30/14 at 10:20 AM, revealed he inspected resident rooms everyday and thought that the rooms needed some waxing done to the floors. The Housekeeping Manager stated when the staff deep cleaned they should clean the toilets in the resident rooms. The Housekeeping Manager stated he informed the Maintenance Director that the staff could not get the stains off the tiles and the toilets needed to be re-caulked. The Housekeeping Manager stated he was responsible to ensure the bathrooms were cleaned and honestly was not monitoring the resident bathrooms. The Housekeeping Manager stated the bathrooms in the resident rooms did not look clean and had a urine odor. Further interview with the Housekeeping Manager, on 07/30/14 at 11:21 AM, revealed the residents probably felt upset when their bathrooms were not cleaned.

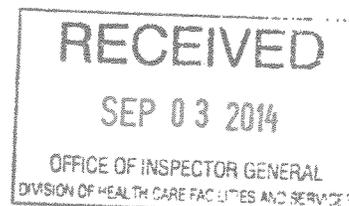
Interview with the Interm Maintenance Director, on 07/31/14 at 1:23 PM, revealed the Administrator had talked to him about the appearance of the bathrooms that day. The Interm Maintenance Director stated he talked about painting the walls, changing the curtains in resident rooms and replacing the tiles because of discoloration. The Maintenance Director was not

F 253 8/18/2014 regarding the regulation tag F253 to define environment, the intent of the regulation, guidelines for preventing spread of infection, definition of sanitary, what should be involved with cleaning a resident bathroom and maintaining it, frequency of daily cleaning and deep cleans, and documentation checklist for what housekeeping staff clean daily and with deep cleans. In addition, the housekeeping daily cleaning checklist was revised to include the specific items cited in this statement of deficiency and a deep clean resident room checklist (which includes the bathroom) was developed and implemented by 8/18/2014.

Housekeeping/Laundry Supervisor educated and trained the housekeeping staff to F253 as described previously and introduced them to the daily and deep cleaning documentation checklist. This was accomplished by 8/19/2014.

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 8/22/2014.

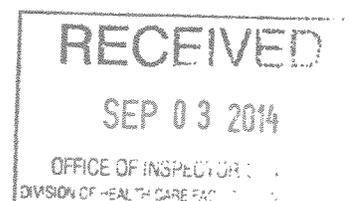
As an additional measure, the Administrator obtained quotes from a local floor vendor to replace the flooring in all of the resident bathrooms in the facility. This quote was processed up through the corporate channels and was approved on 8/15/2014. Once vendor receives the supplies needed to do



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F 253	Continued From page 3 aware of the problems with the bathrooms because he had only been the Interm Maintenance Director for three (3) weeks. Interview with the Administrator, on 07/30/14 at 10:40 AM, revealed she was not sure if she had ordered tile for the bathrooms. She stated she had talked to the Maintenance Director a few weeks before he left about the caulking in the bathrooms, but did not follow up with it. The Administrator stated housekeeping was supposed to monitor the resident rooms for cleanliness. Further interview with the Administrator, on 07/31/14 at 1:47 PM, revealed she was borrowing the Interm Maintenance Director from another facility. The Administrator stated she thought the build up of the dirt needed to have some attention, but felt the stains were not dirt.	F 253	the installed it will take place and be completed. The following monitoring has been put into place to ensure for compliance with this regulation in relation to resident bathrooms: Effective 8/21/2014, Housekeeping/Laundry Supervisor will audit the cleaning of five resident bathroom cleanings to ensure that housekeeping staff are maintaining the bathrooms to ensure for on-going compliance with this regulation. This will occur five days a week for 12 weeks. (Continued on page 4a)		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Water Temperature Log policy, it was determined the facility failed to ensure a safe environment regarding water temperatures which exceeded 110 degrees Fahrenheit (F), in	F 323	F323 Completion Date 8/26/2014 SS=E Free of Accident Hazards/Supervision/Devices The specific residents that were cited in the statement of deficiency as having been affected were as follows: Resident rooms #3, #6, #20, and the shower room on Lincoln Lane and Heritage Hall. Maintenance Supervisor and/or Housekeeping/Laundry Supervisor checked the above cited resident rooms for water temperatures on the following dates: 8/13/14, 8/14/14, 8/15/14 and the water temperatures have ranged from 100.4		



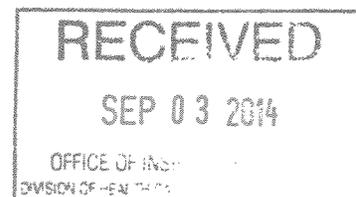
(Continued from Page 4 for F253)

Each week the administrator will review this audit documentation to ensure that on-going monitoring and compliance regarding resident bathroom cleaning is sustained for compliance with this regulation.

To ensure that compliance and improvements are sustained, after the initial 12 weeks of monitoring, the Housekeeping/Laundry Supervisor will audit ten of the monthly deep cleans of resident bathrooms until the next facility's annual survey.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) 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 as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, business office manager, unit manager, and the
(Continued on page 4b)

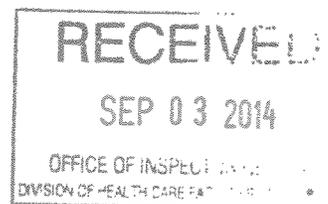
Page 4a



(Continued from Page 4a for F253)

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.

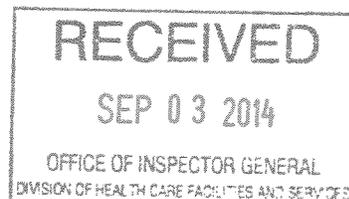
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F 323	Continued From page 4 three (3) of five (5) resident rooms, (rooms #3, #16 and #20) and two (2) of two (2) shower rooms on Lincoln Lane and Heritage Hall. Water temperatures were as high as 116.6 degrees (F) during the environmental tour. The findings include: Review of the Water Temperature Log Policy, not dated, revealed the temperature of all domestic hot water systems must be checked every day and logged for that day. The required temperature allowable varies by state and each facility must know what the temperature requirement was (Kentucky 100-110 degrees F). Any temperature found to be out of range (either too hot or too cold) should be re-checked to confirm and the cause or reason for those temperatures must be investigated and corrected. Observations of water temperatures during the environmental tour, on 07/29/14 at 12:10 PM, revealed room #3 had a water temperature of 112 degrees (F), room #16 had a water temperature of 116.6 degrees (F), and room 20 had a temperature of 114.5 degrees (F). Further observation of water temperatures, revealed the shower room on Lincoln Lane had a water temperature of 115.4 degrees (F) and the shower room on Heritage Hall had a water temperature of 111 degrees (F). Review of the water temperature logs, dated 06/30/14 to 07/29/14, revealed the water temperatures were completed daily with no concerns. Interview with the Maintenance Director, on 07/29/14 at 1:26 PM, revealed the in-line on the	F 323	degrees(F) to 107.8 degrees (F). All of these water temperatures have been within the State regulations for water temperatures --- 100 degrees (F) - 110 degrees (F). Administrator had the facility plumbing vendor to replace the mixing valve on the hot water boiler tank and there were four faucets, valves, and stems in sinks located in resident areas replaced. This was completed on 8/1/2014. Housekeeping/Laundry Supervisor completed an audit of all water temperatures in all resident areas and the two shower rooms from 8/13/2014 thru 8/15/2014 and the water temperatures ranged from 100.4 degrees(F) to 107.6 degrees (F). All of these water temperatures were within the State regulation for water temperatures -- - 100 degrees (F) - 110 Degrees (F). Administrator had the facility plumbing vendor to replace the mixing valve on the hot water boiler tank and there were four faucets, valves, and stems in sinks located in resident areas replaced. This was completed on 8/1/2014. The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:		



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F 323 Continued From page 5
mixing valve was reading 115 degrees (F). The Maintenance Director stated he liked for the in-line to read 105 degrees (F). The Maintenance Director stated he monitored the in-line once a week, but water temperatures were monitored daily.

Further interview with the Maintenance Director, on 07/31/14 at 1:23 PM, revealed he would like for the water temperatures to be between 100 to 110 degrees (F). The Maintenance Director stated if the water temperatures were above 110 degrees (F), a resident hands could become scalded.

Interview with the Administrator, on 07/31/14 at 1:47 PM, revealed water temperatures should be 100 to 110 degrees (F) to ensure resident safety and that no one gets burned. The Administrator stated she monitored water temperatures and was not aware of any concerns with the temperature of the water.

F 371 483.35(i) FOOD PROCURE, SS=F STORE/PREPARE/SERVE - SANITARY

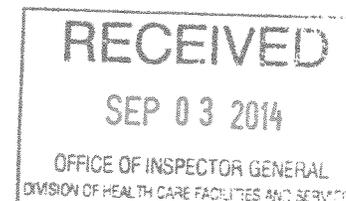
- The facility must -
- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
 - (2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

F 323 Administrator completed education/training to the housekeeping/laundry supervisor, maintenance supervisor, and all staff who rotate through a schedule for weekend/holiday manager on-duty (business office manager, human resource/payroll assistant, social service director, director of nursing, assistant director of nursing, LPN unit manager, director of sales & marketing, activity director, dietary manager, MDS LPN coordinator, and the medical records/supply coordinator). This education/training consisted of review of F323 regulation, its intent, definitions of accidents (avoidable and unavoidable), using a systematic approach for resident safety --- identify hazards and risks; evaluate and analyze hazards and risks; implement interventions to reduce hazards and risks; and monitoring for effectiveness of (Continued on page 6a)

F 371

F371 Completion Date: 8/26/2014
SS=F
483.35(i) Food Procure, Store/Prepare/Serve - Sanitary --- regarding labeling food contents and dating



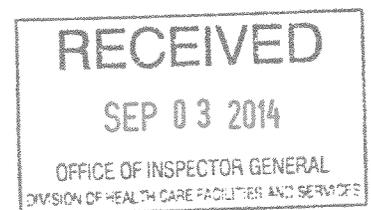
(Continued from Page 6 for F323)

interventions and modifying if necessary. In addition, education/training was provided regarding water temperatures, state regulations for water temperatures, and the process the facility is implementing to check/monitor water temperatures seven days per week. This process identified 23 different resident areas for which water temperatures will be taking, by having four zones so that water temperatures are taken at the front, middle, and back of both resident hallways on a weekly schedule. Staff competency testing was completed for all of the staff having responsibility for checking/monitoring water temperatures, and all scored 90% or better for this competency compliance. This was all completed by 8/19/2014.

The following monitoring has been put into place to ensure for compliance with this regulation in relation to water temperatures:

Maintenance Supervisor will be responsible for checking/monitoring and documenting daily water temperatures according to the established weekly schedule and will document the water temperatures into the TELS System. The Housekeeping/Laundry Supervisor will be the back-up for checking/monitoring water temperatures

Page 6a



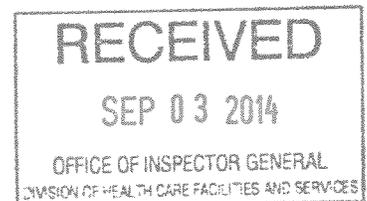
(Continued from Page 6a for F323)

during the week. Then for weekends/holidays, the manager on-duty will check/monitor water temperatures according to the established weekly schedule.

Each week the administrator will monitor the water temperature documentation for compliance with the process and schedule that has been implemented.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) 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 as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee

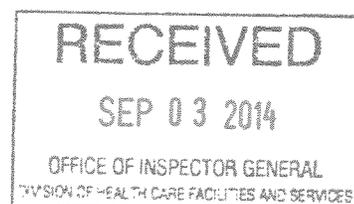
Page 6b



(Continued from Page 6b for F323)

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

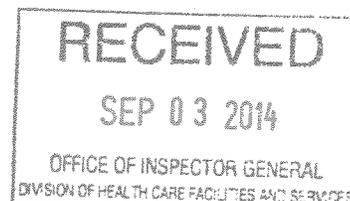
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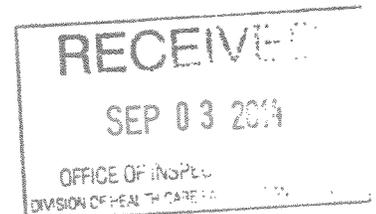
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F 371	<p>Continued From page 6</p> <p>Based on observation, interview, record review, and review of the facility's policy Food Receiving and Storage, it was determined the facility failed to ensure food stored in one (1) of one (1) freezers were labeled and dated. Four packages of food (not in original containers) were observed in the kitchen freezer which were not dated and not labeled.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Food Receiving and Storage, revised December 2008, revealed all food stored in the freezer would be covered, labeled, and dated.</p> <p>Observation of the kitchen, on 7/29/14 at 8:35 AM, revealed four (4) plastic storage bags with biscuits, garlic bread, meat patties, and Tatar tots in the walk-in freezer that were not labeled with the contents or dated when opened.</p> <p>Interview with the Dietary Manager, on 7/29/14 at 8:47 AM, revealed she was responsible for monitoring the storage and labeling of the frozen foods. She stated she monitored the shelves of the freezer daily for labeled and outdated foods, but she had not conducted a check on 7/28/14. The Dietary Manager stated she had recognized a problem with the dating and labeling of food items and had recently conducted training with dietary staff. She further revealed all new dietary staff were trained on food labeling during orientation. The dietary manager stated there was a potential for food-borne illness as a result of serving outdated food.</p> <p>Review of Dietary Aide Training, undated,</p>	F 371	<p>No specific residents were cited in the statement of deficiency as having been affected; however, the first day of survey the census was at 63.</p> <p>The four packages of food that were not in their original containers, in the freezer, that were not labeled for content and were not dated were disposed of by the Dietary Manager immediately upon discovery on 7/29/2014.</p> <p>Dietary Manager has been completing a "Dietary Daily Checklist" five times weekly since 7/30/2014 that includes checking to make sure all food items (in freezer, refrigerators, and dry food pantry storage room) that have been open are labeled for content and dated. Any items found unlabeled for content and date has been disposed of immediately.</p> <p>Administrator has reviewed the dietary checklist to ensure that monitoring has been done by the dietary manager for ensuring compliance with food being labeled for content and dated.</p> <p>No other residents were identified as having the potential to be affected; however, first day of survey the census was at 63.</p> <p>The four packages of food that were not in their original containers, in the freezer, that were not labeled for content and were not</p>



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2014
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
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F 371	Continued From page 7 revealed the Dietary Manager reviewed food item labeling during new-hire orientation. Review of the In-Service Training Record, dated 11/12/13, revealed the dietary staff was trained on the labeling and dating of food items. The training objective revealed all food items placed in the refrigerator would have an open date, including food items that had been removed from the original packaging.	F 371	dated were disposed of by the Dietary Manager immediately upon discovery on 7/29/2014. (Continued on page 8a)
F 441 SS=D	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	F 441	F441 Completion Date 8/26/2014 SS=D Infection Control, Prevent Spread, Linens The specific residents that were cited in the statement of deficiency as having been affected were as follows: Resident #1 and Resident #5 for LPN # 1 and LPN #2 not performing hand hygiene and wound dressing care according to infection control regulations and the facility policies. LPN#1 and LPN#2 received re-education/training by Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 7/30/2014, on proper hand hygiene, to make sure gloves are changed and hands washed upon exiting a resident room and during direct care with residents. Re-education/training also consisted of not touching any area of a resident's body with contaminated gloves after providing peri-care; including any areas with wounds. Hands are to be washed before and after donning gloves.



(Continued from page 8 for F371)

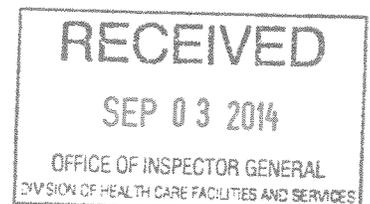
Dietary Manager has been completing a "Dietary Daily Checklist" five times weekly since 7/30/2014 that includes checking to make sure all food items (in freezer, refrigerators, and dry food pantry storage room) that have been open are labeled for content and dated. Any items found unlabeled for content and date has been disposed of immediately.

Administrator has reviewed the dietary checklist to ensure that monitoring has been done by the dietary manager for ensuring compliance with food being labeled for content and dated.

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

The administrator provided education/training to the dietary manager regarding F371 dietary regulations that included all of the following: all food must be procured from sources approved or considered satisfactory by Federal, State, or Local authorities; food must be stored, prepared, distributed and served under sanitary conditions; all food items stored must be labeled for contents and dated; review of the food receiving and storage

Page 8a



(Continued from page 8a for F371)

policy; and the importance of ensuring that the dietary daily checklist is completed at least five times per week to ensure that dietary staff are in compliance with this dietary regulation. This was completed on 8/18/2014.

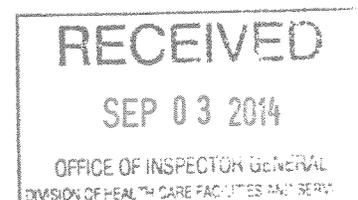
Dietary Manager then conducted this dietary training to all the dietary staff to ensure compliance with this 371 dietary standard and this was completed by 8/20/2014.

Dietary Manager and all dietary staff were administered a dietary competency test that addressed the 371 dietary regulation and had to score at least 90% or above. This was completed by 8/20/2014.

Dietary Manager will complete the monitoring of the dietary department (to include the labeling and dating) by utilizing a dietary daily checklist. This will be completed at least five times per week and results will be documented as to findings and action taken. This monitoring started on 8/19/2014 and will continue until the next facility's annual survey.

Each week the administrator will monitor the dietary daily checklist documentation, that is completed by the dietary manager for compliance with the process that has been implemented.

Page 8b

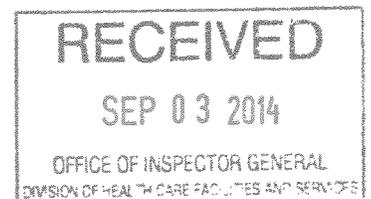


(Continued from page 8b for F371)

To ensure that improvements are sustained, the Dietary Manager will continue monitoring for three times per week (after the initial 12 weeks) until the facility's next annual survey.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the facility's next annual survey) 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 as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, business office manager, unit manager, 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.

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F 441 Continued From page 8
hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy Handwashing/Hand Hygiene, it was determined the facility failed to ensure staff used proper hand washing and glove technique during wound care for two (2) of sixteen (16) sampled residents (Resident #1 and #5). Licensed Practical Nurse (LPN) #2 provided incontinent care for Resident #1 and then applied Bactroban cream directly to the resident's wound with a soiled glove. In addition, LPN #1 provided incontinent care and wound care for Resident #5 and failed to wash hands when exiting and re-entering the room. LPN #1 was observed to cross contaminate the medication cart on two (2) separate occasions after exiting Resident #5's room.

The findings include:

Review of the facility's policy regarding Handwashing/Hand Hygiene, revised June 2010, revealed employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water before and after direct resident contact, changing a dressing, handling soiled or used linens and dressings, and

F 441

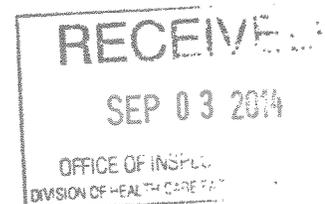
All residents have a potential to be affected by improper infection control practices, and on the first day of the survey the facility census was at 63.

All licenses nursing staff were re-educated and trained by the DON and ADON when providing direct resident care hands are to be washed prior to and after donning gloves. Gloves are never to be worn after leaving a resident room and to never touch a clean area of a resident body after touching a dirty area. This was completed by 8/22/2014.

All licensed nursing staff were re-educated/trained on hand hygiene and glove usage to prevent spread of infections, as outlined in the F441 regulations and facility hand-washing policy. This was completed by the DON and ADON by 8/22/2014.

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

All licensed nursing staff will receive re-education/training regarding the infection control regulations for F441, the facility hand-washing policy, and the facility wound care policy. This will be conducted by the DON and ADON and will be completed by 8/22/2014.



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F 441 Continued From page 9
after removing gloves. The policy further revealed the use of gloves did not replace hand washing/hand hygiene.

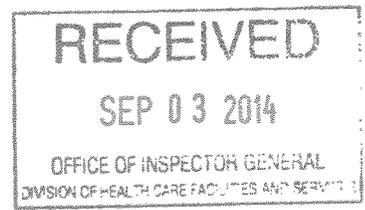
1. Review of the clinical record for Resident #5 revealed the facility admitted the resident on 07/20/14 with diagnoses of Pneumonia, Chronic Anemia, Fracture of Left Hip, Dementia, Atrial Fibrillation, and Gastroesophageal Reflux. Review of the Wound Healing Progress Report, dated 07/24/14, revealed the resident had an open sacral wound.

Observation of a wound care treatment for Resident #5, on 7/30/14 at 10:15 AM, with LPN #1 revealed she cleansed the sacral wound with a sterile gauze soaked with normal saline, removed her gloves and donned clean gloves without washing her hands. LPN #1 then applied Baza cream to the wound with a sterile cotton tipped applicator, covered the wound with an ABD pad, and secured the pad with paper tape. LPN #1 removed her gloves, opened and then closed the bathroom door, proceeded to the bedside nightstand, opened the drawer and removed a new brief. The nurse donned clean gloves, performed incontinent care, and removed her gloves. She then straightened the bed linens and adjusted the head of the bed for Resident #5 with her bare hands. The LPN picked up the trash bag containing the soiled wound dressing, exited the room to the hallway, disposed of the trash, and went to the medication cart with soiled hands and obtained a clean trash bag. The nurse returned to the resident's room with the trash bag, donned gloves, collected the dirty linens, and removed her gloves. She exited the room, disposed of the bag of dirty linens in the dirty linen cart sitting in the hallway, and returned to

F 441 In addition, all other facility staff will receive re-education/training to the infection control regulation F441 and the facility policy on hand-washing by the Director of Nursing and/or Assistant Director of Nursing by 8/22/2014.

The DON and ADON will ensure that when completing orientation for newly employed licensed nursing staff, that they are aware of responsibilities outlined above as part of their orientation training and competency for infection control practices. This is effective starting 8/22/2014.

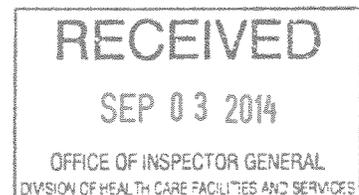
The DON and the ADON will conduct weekly random auditing/monitoring of direct observation for proper infection control practices, washing hands, glove use, and possible cross contamination. This random auditing/monitoring will be conducted for all three licensed nursing shifts. Any improper technique will result in an immediate documented on the spot/job training. This process will start for the week of 8/25/2014 and will continue for the next 12 weeks. Then auditing/monitoring will be reduced to ten per month until the facility's next annual survey.



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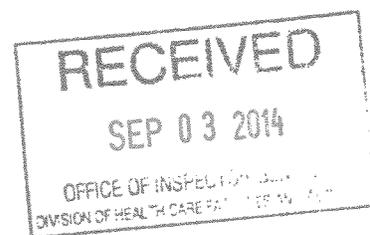
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F 441	<p>Continued From page 10</p> <p>the resident's room. The LPN gave Resident #5 his/her call light, gathered the wound care supplies, and exited the room. She went to the medication cart, picked up a nasal spray box lying on top of the cart, examined the box, and laid the box back on the top of the cart. LPN #1 did not wash her hands or use hand sanitizer between glove changes, prior to exiting the resident's room or before touching the medication cart.</p> <p>Interview with LPN #1, on 07/30/14 on 10:40 AM, revealed she had received training on infection control and hand washing. She stated she did not realize she had not washed her hands after completing Resident #5's care. The nurse revealed she had cross contaminated the medication cart which could result in the spread of germs or infections to other residents.</p> <p>2. Observation of a wound care treatment for Resident #1, on 07/30/14 at 10:14 AM, with LPN #2 revealed she washed her hands, donned clean gloves, and set up a clean field for her treatment supplies. The nurse removed the old ABD pad from the wound, removed her gloves, donned clean gloves, and cleansed the wound with normal saline and 4 X 4 gauze. The LPN then applied cream with a clean 4 X 4 gauze and covered the wound with a clean ABD pad. She then proceeded to provide incontinent care for the resident. The LPN removed the ABD pad from the old brief, and put the pad inside the clean brief. The nurse then put the Bactroban/Zinc cream on her gloved hand and applied the cream directly on the resident's wound. She then removed her gloves and washed her hands.</p>	F 441	<p>The following monitoring has been put into place to ensure for compliance with this regulation in relation to infection control:</p> <p>The Administrator and the DON will monitor to ensure that the random auditing/monitoring for the direct observations on licensed nursing staff for all three shifts is completed as outlined for infection control regulations, hand hygiene and with performing wound care.</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 (until the facility's next annual survey) 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 monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, business office manager, unit manager, 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</p>	



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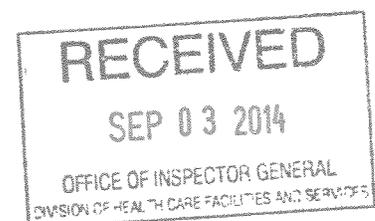
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F 441	<p>Continued From page 11</p> <p>Interview with LPN #2, on 07/30/14 at 10:20 AM, revealed she did not normally use her gloved hand to apply cream to a wound. The LPN stated she became nervous and thought she had not applied the cream. She further stated she normally used gauze or a cotton tipped applicator to apply cream to a wound site.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 07/31/14 at 2:30 PM, revealed she was responsible for monitoring infection control for the facility. She revealed she conducted three (3) infection control audits a week, including hand washing audits. The ADON revealed she had identified problems with wound care technique during those audits. She stated she was responsible for educating staff on hand washing and infection control. She further stated all staff had been educated on hand washing or use of hand sanitizer between every glove change and after performing resident care.</p> <p>Review of the facility's training record report, dated 07/30/14, revealed LPN #1 had completed infection control training which included hand washing and standard precautions.</p>	F 441	<p>Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>	
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</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>	F 514	<p>Completion Date 8/26/2014 Records-Complete/Accurate/Accessible</p> <p>The specific residents that were cited in the statement of deficiency as having been</p>	



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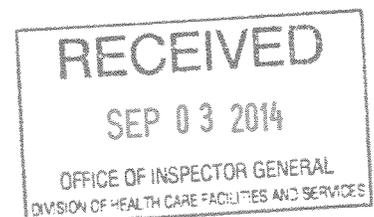
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F 514	Continued From page 12 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy Advance Directives, it was determined the facility failed to maintain accurate and complete medical records for four (4) of sixteen (16) sampled residents, Resident #7, #10, #11, and #12. The facility staff failed to obtain two (2) witness signatures or a notary stamp on the Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order. The findings include: The facility did not provide a policy for maintaining a complete clinical record. Review of the facility's policy regarding Advance Directives, revised April 2008, revealed Do Not Resuscitate was defined as in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) had directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods were to be used. The policy revealed that prior to or upon admission of a resident the Social Services Director or designee would inquire of the resident, and/or his/her family members, about the existence of any written advance directives.	F 514	affected were as follows: Resident #7, #10, #11, and #12. The Director of Nursing (who is a notary public) received two signatures on the Kentucky Emergency Medical Services Do Not Resuscitate (DNR) orders for the above cited residents. This was completed by 8/14/2014. All residents have a potential to be affected by this deficient practices, and on the first day of the survey the facility census was at 63. All resident medical records were reviewed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to ensure all had a DNR and Full Code status; and if a DNR signature with two witnesses were obtained in the presence of the notary public and notrized or witnessed with two valid signatures and dated. This process was completed by 8/22/2014. The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following: The facility policy on Advanced Directives was revised by the Director of Nursing on		



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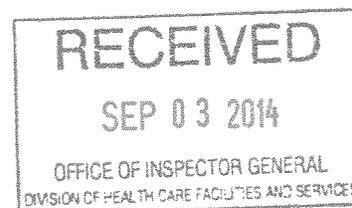
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 514	<p>Continued From page 13</p> <p>In addition, the policy stated the Interdisciplinary Team would review annually with the resident his or her advance directives to ensure that such directives were still the wishes of the resident.</p> <p>Review of the Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order form revealed a signature line for the person/legal surrogate, an area for the form to be notarized, and signature lines for two (2) witnesses.</p> <p>1. Review of the medical record for Resident #10, revealed the facility admitted the resident on 05/24/14. Review of the Kentucky Emergency Medical Services (EMS) DNR Order form for Resident #10 revealed the resident had signed the form on 06/03/14 to initiate the DNR order. Further review revealed the EMS DNR Order form had not been notarized or signed by witnesses.</p> <p>2. Review of the medical record for Resident #12 revealed the facility admitted the resident on 01/23/14. Further review of the resident's medical record revealed the Kentucky EMS DNR Order form had been signed by the legal surrogate on 01/23/14 to initiate the DNR order, but had not been notarized or signed by witnesses.</p> <p>Interview with the Social Services Director (SSD), on 07/31/14 at 10:55 AM, revealed the nursing staff was responsible for obtaining the resident's signed Kentucky EMS DNR consent upon admission to the facility. She further revealed she was responsible for verifying the accuracy and completeness of all DNR consents. She stated she was responsible for checking the DNR consents with the completion of the five (5) day</p>	F 514	<p>8/15/2014; and approved by the Administrator on 8/15/2014.</p> <p>Director of Nursing provided education/training to the facility Director of Sales & Marketing and the Social Service Director to ensure the Kentucky Emergency Medical Services' DNR has been signed, witnessed, and notarized, as appropriate upon a resident admitting to the facility.</p> <p>Starting 8/18/2014 all new admissions' medical records will be reviewed in the facility clinical morning meeting (preferably upon admission) by the Director of Nursing, Assistant Director of Nursing, and/or Social Services Director to ensure that the Kentucky Emergency Medical Services' DNR has been signed, witnessed, and notarized, as appropriate. This will be an on-going process for the facility ensuring compliance with this regulation and the facility policy.</p> <p>All resident DNR or full code status will be reviewed in the resident's care conference for accuracy and completeness by the Social Service Director and annually by Social Service Director and/or Director of Nursing. This will be an on-going process for the facility ensuring compliance with this regulation and the facility policy.</p> <p>The following monitoring has been put into place to ensure for compliance with</p>	



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

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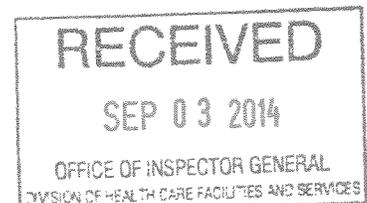
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2014
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 514	Continued From page 14 assessment. The SSD also stated she was responsible for reviewing each resident's DNR status during the care conference, including making sure all DNR forms were signed. The SSD reviewed Resident #10 and #12's Kentucky EMS DNR Order forms and stated the forms were not complete. 3. Review of Resident #11's medical record, revealed the facility admitted the resident on 03/12/13. Review of Resident #11's Quarterly Assessment, dated 05/03/14, revealed Resident #11 had a BIM score of eleven (11) which meant the resident was interviewable and able to sign the Do Not Resuscitate (DNR) form under his/her own volition. Review of Resident #11's, Kentucky Emergency Medical Services Do Not Resuscitate order form, revealed Resident #11 signed on 03/11/13 to initiate his/her DNR status, with no witness to the signing. Interview with Licensed Practical Nurse (LPN) #2, on 07/31/14 at 1:54 PM, revealed upon admission of a resident to the facility, the nurse had to complete admission paper work. LPN #2 stated she had to fill out consent forms, DNR/CPR code status, DNR for EMS Services, personal inventory sheet, etc. LPN #2 stated when she completed the EMS Services DNR form, if the resident was interviewable she would have the resident sign the form. If the resident was not interviewable, LPN #2 would have the Power of Attorney (POA) sign the DNR form. LPN #2 stated she would then have two un-related residents sign the Kentucky EMS DNR form as a	F 514	this regulation in relation to resident advanced directives and code status: The Director of Nursing will document any issues with DNR and advanced directives and will provide a report to the facility's Performance Improvement (PI) Quality Committee for ensuring on-going compliance until the facility's next annual survey. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, director of nursing, assistant director of nursing, business office manager, unit manager, 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.		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2014
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 514	Continued From page 15 witness. LPN #2 stated she was not sure who was responsible to ensure the Kentucky EMS DNR was completed. Further interview with LPN #2, revealed the Kentucky EMS DNR form was not complete. Interview with the Director of Nursing (DON), on 07/31/14 at 2:03 PM, revealed she made observations to ensure the DNR forms were present in the admission packet. The DON stated the goal was to ensure the clinical record was complete. The DON stated she was aware the Admission Clerk met with the residents before admission and thought the business office was completing the DNR and the Kentucky EMS DNR forms because the Admission Clerk completed the legal paper work. The DON stated she was not aware the Kentucky EMS DNR form was not completed with two (2) signatures. The DON stated if the forms were not completed thoroughly, the resident would be a full code (resuscitated) other wise. The DON was aware that the Kentucky EMS DNR form was an important form to have completed and did not want to have residents resuscitated if they did not want to be resuscitated.	F 514		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
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K 000	INITIAL COMMENTS	K 000	
	<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: A new Type II, 80 KW generator was installed in April of 2014. Fuel source is diesel.</p> <p>A recertification Life Safety Code survey was conducted on 07/29/14. The facility 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>		

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

TITLE

(X8) DATE

[Signature]

Administrator

9/3/2014

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.

