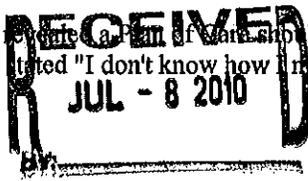


STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>185415</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>6/10/2010</b>
--	-----------------------------	---	---

NAME OF PROVIDER OR SUPPLIER <b>ELLIOTT NURSING AND REHABILITATION CENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY</b>
--	--

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------	-----------------------------------

<p><b>F 279</b></p>	<p><b>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure a Comprehensive Plan of Care was developed related to the needs of one (1) of fifteen (15) sampled residents (Resident # 13). The facility identified through the Minimum Data Set (MDS) that Resident #13 experienced incontinent episodes, however, a Comprehensive Plan of Care was not developed related to urinary incontinence.</p> <p>The findings include:</p> <p>Review of Resident #13's clinical record revealed the resident was admitted with diagnoses which include Depressive Disorder, Insomnia, Dementia with Behavioral Disturbance, Hypertension, Diabetes, and Adult Failure to Thrive.</p> <p>Review of the Annual MDS assessment, dated 01/11/10, revealed the facility assessed Resident #13 as being usually continent and used briefs/pads for incontinent episodes.</p> <p>Review of the Comprehensive Plan of Care dated 01/14/10, revealed no documented evidence a Plan of Care had been developed related to the Residents #13's urinary incontinence.</p> <p>Interview with RN #2/MDS Coordinator on 06/10/10 at 10:05 AM revealed a Plan of Care should have been developed related to the residents urinary incontinence. She further stated "I don't know how I missed it".</p> <div style="text-align: center;">  </div>
---------------------	---

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

The above isolated deficiencies pose no actual harm to the residents

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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  A Recertification and Abbreviated Survey related to AROs KY00014829 and KY00014917 was conducted on 06/08-10/10. Deficiencies were cited with the highest scope/severity of a "F". A Life Safety Code Survey was conducted on 06/10/10 with deficiencies cited. KY00014829 was determined to be unsubstantiated with no deficient practice cited, and KY00014917 was determined to be substantiated with deficient practice cited.	F 000	To the best of my knowledge and belief, as an agent of Elliott Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements.	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE  Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.  Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.  Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this	F 203	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.  It is the policy of Elliott Nursing and Rehabilitation Center that before the center transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of the section 483.12.  The discharge letter for resident #13 was rescinded on June 9, 2010.  There have been no other discharge letters issued in this facility for the last five (5) years.	7/20/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bernita Adkins</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/1/10</i>
--	-------------------------------	----------------------------

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: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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 203	<p>Continued From page 1</p> <p>section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure all of the necessary criteria related to a discharge notice for Resident # 13, related to the effective date of the discharge and the location to which the resident was to be discharged.</p> <p>The findings include:</p> <p>Review of Resident #13's medical record revealed an admission date of 02/02/09, and diagnosis which included Depressive Disorder,</p>	F 203	<p>The administrator has reviewed the facility discharge letter and made changes to the form as indicated to include the effective date of the discharge and the location to which the resident will be discharged.</p> <p>The facility Continuous Quality Improvement (CQI) Committee will review the facility discharge letter at least annually to determine that all necessary criteria are included in the facility discharge letter.</p>		

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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 203	Continued From page 2 Insomnia, Dementia with Behavioral Disturbance, Hypertension, Diabetes and Adult Failure to Thrive. Review of the Minimum Data Set (MDS) dated 01/12/10, revealed the facility assessed Resident #13 as having both long and short term memory problems and moderately impaired with cognitive skills related to daily decision making.  Review of the Social Services note dated 05/21/10, revealed the Ombudsman had come and talked with Resident #13 in regarding non-payment issues with the family.  Review of the facility's discharge notice date 05/19/10, revealed the letter failed to contain the effective date of the discharge and the location to which the resident was to be discharged.	F 203		
F 281 SS=D	<b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure Physicians' orders were followed, therefore, failed to provide services to meet professional standards of quality for one (1) of fifteen (15) sampled residents (Resident #12).  The findings include:  Review of Resident #12's clinical record revealed diagnoses which included Dementia-Alzheimers type, Psychosis, Behavioral disturbance and Depression. Review of the Physician's Orders	F 281	It is the policy of Elliott Nursing and Rehabilitation Center to have services provided or arranged by the facility that meet professional standards of quality.  Resident #12 was assessed on June 10, 2010 by the charge nurse. The assessment indicated that the restraint free alarm was not beneficial to the patient at this time. The device was then discontinued by physician order on June 10.  The Director of Nursing, MDS Coordinator, and RN Supervisor reviewed all physician orders on June 29 and June 30 to ensure that physician orders for all residents were current, appropriate and implemented as directed by the physician. The physician was notified of any discrepancies.	7/20/10

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/10/2010
NAME OF PROVIDER OR SUPPLIER  ELLIOTT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 281	Continued From page 3 revealed an order dated 05/30/10 for a Restraint Free Alarm (RFA) to be used at all times.  Observations on 6/10/10 at 8:35 AM and 9:20 AM revealed no RFA in use. Observation at 10:10 AM, on that same day, with Licensed Practical Nurse (LPN) #1 revealed no alarm in use.  Interview on 6/10/10 at 10:35 AM with LPN #1 revealed the Physicians' order for a RFA at all times was a current order and that the alarm should be in use.  Interview on 6/10/10 at 2:00 PM with the Director Of Nursing (DON) revealed the RFA order was current and that the alarm should have been in use.	F 281	All nursing staff will receive additional education by July 15 by the Director of Nursing regarding the importance of implementing physician orders as directed and providing services as directed by the plan of care.  The DON/designee, via daily compliance rounds (Monday-Friday), will audit at least three physician orders per day for four weeks to ensure that the orders continue to be appropriate for the resident and have been implemented as directed by the physician. The results will be forwarded to the monthly CQI Committee meeting for continued compliance.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure Care Plans were followed one (1) of fifteen (15) sampled residents (Resident #12). Resident #12 failed to have an alarm in place  The findings include:  Review of the clinical record of Resident #12 revealed an admission date of 06/04/07 with diagnoses which included Dementia-Alzheimer's	F 282	It is the policy of Elliott Nursing and Rehabilitation Center that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  The IDCPT reviewed and revised the care plan for resident # 12 on June 10, 2010 to reflect the physician's order dated June 10 discontinuing the use of restraint free alarm for this resident.  The IDCPT reviewed the plan of care for all residents on June 16, June 23, and June 24 to ensure that care plan interventions were current, appropriate and implemented as directed.	7/20/10

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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)	(X6) COMPLETION DATE	
F 282	Continued From page 4 type, Psychosis, Behavioral disturbance and Depression. Review of the Care Plans revealed approaches which included a Restraint Free Alarm (RFA) to be used at all times.  Observations on 6/10/10 at 8:35 AM and 9:20 AM revealed no RFA in use. Observation at 10:10 AM with Licensed Practical Nurse (LPN) #1 revealed no alarm was in use.  Interview on 6/10/10 at 2:00 PM with the Director Of Nursing (DON) revealed the RFA was on the Care Plan and that the alarm should have been in use.	F 282	The IDCPT will receive additional education by the Director of Nursing by July 15 regarding the importance of ensuring that care plan interventions were current and implemented as directed by the plan of care.  The IDCPT will audit, via walking care plan rounds, at least one care plan per day for four weeks to ensure that all interventions are current and implemented as directed by the plan of care. The results of these audits will be forwarded to the monthly CQI Committee meeting for continued compliance.		
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 and interview, it was determined the facility failed to ensure the residents' environment remained free from accidental hazards as evidenced by: storage of chemicals in unlocked shower rooms, unlocked housekeeping carts being accessible to wandering residents, water temperature 130.3 degrees Farenheit in a residents' room, a treatment cart unlocked and accessible to residents, telephone cords stretched across the floor in four (4) resident rooms, and toilets with	F 323	It is the policy of Elliott Nursing and Rehabilitation Center to 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.  The chemicals in the shower room were placed in a locked cabinet on June 9, 2010 by the Housekeeping Supervisor.  A lock was placed on each housekeeping cart cabinet by the Maintenance Supervisor on June 10, 2010 to ensure safe storage of chemicals.  The toilet bolts covers were applied to all toilets by the Maintenance Supervisor on June 14, 2010.	7/20/10	

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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 323	<p>Continued From page 5</p> <p>uncovered bolts in residents' bathrooms and shower rooms.</p> <p>The findings include:</p> <p>Observation of the Shower Rooms on the right and left side of the 100 hall on 06/08/10 at 10:35 AM revealed storage of chemicals in the unlocked shower rooms and in unlocked housekeeping carts which were accessible to residents. The chemicals included: Husky Crème Cleanser, Comet with bleach, (Warnings on the label included: Danger, Keep out of reach of children, corrosive, may cause eye irritation and harmful if swallowed, Call Poison Control or MD), Virex 256 (Warnings on the label included: Keep out of reach of children, Caution causes moderate eye irritation, avoid contact with eyes, skin, clothing, Contact Poison Control or MD), The Material Safety Data Sheet warnings include: Inhalation of mists may cause irritation to nose, throat and mucous membranes, Ingestion may cause nausea, vomiting, and gastrointestinal irritation, swelling of the larynx, respiratory distress, circulatory shock and convulsions, Skin contact may cause mild to severe irritation dependant upon the degree of exposure, Eye contact is corrosive, causes eye burns, may cause temporary or permanent vision loss and blindness, Acute and Chronic: Corrosive to all body tissues, harmful skin contact may not cause immediate pain.</p> <p>Observation of the shower rooms on the right and left side of the 100 hall on 06/09/10 at 9:15 AM during the environmental tour revealed the above chemicals were still stored in the unlocked shower rooms and housekeeping carts. Continued observation of the facility revealed</p>	F 323	<p>The water temps on the Lighthouse unit were adjusted by the Maintenance Supervisor to bring the water temps within an acceptable range on June 9.</p> <p>The unlocked treatment cart was locked on by the RN Supervisor on June 9.</p> <p>The phone cords in rooms 103, 208, 212, 213 were rerouted by the Maintenance Supervisor on June 15.</p> <p>An environmental audit was conducted by the Administrator and the Maintenance Supervisor on June 25 to ensure that the environment remains as free of accident hazards as possible.</p> <p>The Maintenance Supervisor will conduct weekly environmental rounds for four weeks to ensure that the environment remains as free of accident hazards as possible. Audits will be conducted quarterly thereafter. The results of these audits will be forwarded to the CQI Committee monthly meeting for continued compliance.</p>		

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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 323	<p>Continued From page 6</p> <p>toilets to have long bolts sticking up out of the base with no covering in resident rooms and shower rooms. The water temperature on the Light House Unit in room 404 was 130.3 degrees Fahrenheit (F). Also, a treatment cart was observed to be unlocked with medicated creams and ointments accessible to residents. Further observation of the facility revealed telephone cords stretched across the floor in four (4) residents rooms, room numbers 103, 208, 212 and 213.</p> <p>Interview with the Maintenance Director at 4:00 PM on 06/09/10 revealed he was not aware that the toilet base bolt covers needed to be replaced. He further stated "the phone jacks are on the wrong side of the room I've tacked the cord around the wall but it just gets pulled loose, we have to figure something out, I know it could cause accidents".</p> <p>Interview with housekeeper #9 revealed there were no keys for the housekeeping carts, in order to lock and/or unlock them. She further stated " I try to keep an eye on my cart and I keep my cleaning chemicals here inside the door, I know it would hurt a resident if they got into them and drank it".</p> <p>Interview with the Housekeeping Supervisor on 06/09/10 at 2:00 PM revealed she was aware that the carts did not lock.</p> <p>Interview with the Administrator on 06/09/10 at 2:05 PM revealed she was unaware the housekeeping carts were not being locked.</p>	F 323		
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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

PRINTED: 08/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/10/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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 371	<p>Continued From page 7</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observation on 06/08/10 at 10:55 AM revealed a dirty individual serving bowl stored with the clean bowls, four black plates which were stored wet, and seven coffee cups which had crumbs on the inside which were found to be stored with the clean cups. Observation on several occasions revealed the walk-in freezer's temperature to be nineteen to twenty degrees Fahrenheit.</p> <p>The findings include:</p> <p>1. Observation on 06/08/10 at 10:55 AM revealed a dirty individual serving bowl stored with the clean bowls.</p> <p>Interview with Dietary Supervisor on 06/08/10 at 11:00 AM revealed the bowl was dirty and should not have been stored with the clean bowls. The Dietary Manager removed the bowl and sent it to the dishwasher.</p> <p>2. Observation on 06/08/10 at 10:55 AM</p>	F 371	<p>It is the policy of Elliott Nursing and Rehabilitation Center to store, prepare, distribute and serve food under sanitary conditions.</p> <p>The dirty bowl was removed from storage and placed in the dishroom for rewashing by the Dietary Manager on June 8.</p> <p>The wet plates were removed from storage and placed in the dishroom for rewashing by the Dietary Manager on June 8.</p> <p>The coffee cups were removed from storage and placed in the dishroom for rewashing by the Dietary Manager on June 8.</p> <p>The freezer seal and door closure was replaced by an outside vendor specializing in refrigeration on June 16. Additional maintenance is scheduled for the freezer on July 14.</p> <p>All dietary staff received additional education by the Dietary Manager on June 8, 9, and 10<sup>th</sup> regarding the importance of storing, preparing, distributing, and serving food under sanitary conditions. Facility sanitation protocols were reviewed with all dietary staff to ensure understanding of facility expectations.</p>	7/20/10
-------	--	-------	---	---------

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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 371	<p>Continued From page 8</p> <p>revealed four black plates which were stored wet on the same shelf as clean dishes, which were to be used on the resident tray line.</p> <p>Interview with the Dietary Supervisor on 06/08/10 at 11:00 AM revealed the plates were stored wet and they should not be secondary to bacteria growth. The Dietary Supervisor sent the plates back to the dishwasher.</p> <p>3. Observation on 06/08/10 at 11:20 AM revealed the presence of seven coffee cups which had been stored in the cafeteria area with crumbs inside of them.</p> <p>Interview with Dietary Supervisor on 06/08/10 at 11:25 AM revealed the dirty cups should not have been stored with the clean cups, as residents used those cups to get their own coffee. The Dietary Supervisor proceeded to transport the dirty coffee cups to the dishwasher.</p> <p>4. Observation of the walk-in freezer on 06/08/10 at 10:55 AM revealed the freezer temperature was nineteen degrees Fahrenheit.</p> <p>Observation of the walk-in freezer on 06/09/10 at 2:30 PM revealed the freezer temperature was twenty degrees Fahrenheit. There was ice attached to a bolt from the ceiling of the freezer, on the edges of the shelf and on the floor.</p> <p>Observation of the walk-in freezer on 06/09/10 at 4:00 PM revealed the freezer temperature was twenty degrees Fahrenheit.</p> <p>Observation of the walk-in freezer on 06/10/10 at 9:05 AM revealed the freezer temperature was five degrees Fahrenheit.</p>	F 371	<p>The dietary manager will conduct sanitation audits, via daily compliance rounds (Monday-Friday), each day for four weeks to ensure that facility protocols regarding sanitation are observed. The Dietary Manager will also maintain and monitor a temperature log documenting freezer temperatures twice each day by dietary staff to ensure temperatures remain within compliance. The results of the sanitation audits and the temperature logs will be forwarded to the monthly CQI Committee meeting for continued compliance.</p>	

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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 371	Continued From page 9 The Dietary Supervisor stated in interview on 06/09/10 at 2:30 PM that the freezer would go through defrost approximately three times each day and perhaps that could explain why the temperature was too high.  Interview on 06/10/10 at 9:15 AM with the Dietary Supervisor and Registered Dietitian revealed a seal and a door closure had been ordered in the month of May 2010 for the door of the freezer because it had not been sealing properly. Review of the order form for the seal and door closure revealed the order was placed on 05/22/10 and that the expected arrival date was 06/10/10. Upon looking at the thermometer in the freezer, the Dietary Supervisor stated the temperature was negative fourteen degrees. However, this was temperature in Celsius not Fahrenheit. The actual temperature was 5 degrees Fahrenheit. Freezer units should be kept at zero degrees Fahrenheit or below a two to three degrees variance is allowed.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced	F 465	It is the policy of Elliott Nursing and Rehabilitation Center to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.	7/20/10

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/10/2010
NAME OF PROVIDER OR SUPPLIER  ELLIOTT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 465	<p>Continued From page 10</p> <p>by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary and comfortable environment for residents.</p> <p>The findings include:</p> <p>Observations made during the Environmental Tour beginning on 06/09/10 at 9:15 AM, revealed the following:</p> <p>The shower room on the right side of the 100 hall had tiles missing from the shower stall, three (3) hair brushes with evidence of use and no names were laying on the sink. Code base was coming loose from the wall outside the Activity/Family room. The bathroom in room 214 was missing tile along the floor on one wall and the spa door on the Light House Unit was dragging on the floor. Oxygen concentrators were in use in seven (7) resident rooms which were noted to have build-up of debris (dust) in the filters (room #'s 103, 104, 106, 110, 205, 206, and 209).</p> <p>Interview with the Maintenance Supervisor on 06/09/10 at 4:00 PM revealed that, although there were maintenance work orders at the nursing station, he did not have a work order for the missing tiles in the shower room, room 214's bathroom or the spa door dragging.</p> <p>Interview with the Administrator on 06/09/10 at 4:30 PM revealed the hair brushes should have had resident names ascribed to them, and the brushes were not used as community property.</p> <p>Interview with LPN #2 on 06/10/10 at 9:00 AM revealed Medical Records and Central Supply</p>	F 465	<p>The tile in the 100 hall shower room will be replaced by the Maintenance Supervisor on July 9.</p> <p>The hair brushes were removed by the RN Supervisor on June 9.</p> <p>The cove base in the activity room was replaced by the Maintenance Supervisor on June 9.</p> <p>The missing tile in the bathroom in room 214 was repaired the Maintenance Director on June 10.</p> <p>The spa door in the Lighthouse will be repaired on July 8<sup>th</sup> by the Maintenance Supervisor.</p> <p>The O2 concentrator filters in rooms 103, 104, 106, 110, 205, 206, and 209 were cleaned by Central Supply Clerk on June 9. The protocol for cleaning filters was changed from a weekly schedule to a bi-weekly schedule.</p> <p>Education will be provided to all staff by July 15 regarding generating work order at the time areas of concern are noted.</p> <p>An environmental audit was conducted by the Administrator on June 25, 2010 to ensure that the facility provides a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p>	

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD</b> <b>SANDY HOOK, KY 41171</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)	(X6) COMPLETION DATE	
F 465	Continued From page 11 was responsible for taking care of the oxygen concentrators.  Interview with Medical Records on 06/10/10 at 9:05 AM revealed the Central Supply person was responsible for washing the filters and changing the tubing of oxygen concentrators every Friday. During observation of the oxygen concentrator filters with the Medical Records person she stated "I don't know why they are so dirty maybe because they are close to the bed. I'm not aware of a policy for the cleaning of the oxygen concentrator filters".	F 465	The Maintenance supervisor will conduct weekly environmental audits for four weeks to ensure that the facility environment is safe, functional, sanitary and comfortable. These audits will be forwarded to the monthly CQI committee meeting for further monitoring.		

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

PRINTED: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/10/2010</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000	To the best of my knowledge and belief, as an agent of Elliott Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements.	
K 012 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a combustible canopy at the front of the facility was sprinkler-protected, as required.</p> <p>The findings include:</p> <p>Observation on 06/10/2010 at 11:40 AM, with the Director of Maintenance and the Regional Plant Manager, revealed a canopy of combustible construction (wood), approximately 50 feet by 10 feet in size, located at the front of the facility was noted not to be sprinkler-protected.</p> <p>Interview on 06/10/2010 at 11:40 AM, with the Regional Plant Manager, revealed he was unaware the canopy was not sprinklered.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.</p>	K 012	<p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p> <p>Elliott Nursing &amp; Rehabilitation Center strives to maintain an automatic sprinkler system in accordance with NFPA standards.</p> <p>The facility will expand the current sprinkler system to include the front canopy. This will be installed on July 9 by an outside licensed contractor.</p> <p>Quarterly the sprinkler system will be checked by an outside contractor to assure it is maintained in proper working order.</p> <p>Results of these checks will be forwarded to the facility CQI (continuous quality improvement) Committee for further monitoring and continued compliance.</p>	7/20/10

**RECEIVED**  
JUL 08 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bernita Adkins</i>	TITLE <i>Administrator</i>	(X8) DATE <i>7/1/10</i>
--	-------------------------------	----------------------------

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: 06/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/10/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELLIOTT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171</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)	(X6) COMPLETION DATE	
K 012	Continued From page 1 Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 012			