

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

PRINTED: 08/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2012
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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
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the following action.	
F 225 SS=D	<p>A Recertification Survey was conducted 07/17/12 through 07/20/12. Deficiencies were cited with the highest scope and severity of a "E".</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>	F 225	<p>It is the policy of Elliott Nursing & Rehabilitation Center (ENRC) that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility conducted an internal investigation on the evening of 5/16/12 by the nurse aid extending to the morning of 5/17/12 with several members of the interdisciplinary team including the Administrator. It was determined that the event in question did not meet the requirement for notification of state agency as the occurrence was an accident and did not</p>	8/31/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Berita Adkins</i>	TITLE Administrator	(X8) DATE 8/14/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to have an effective system to ensure all alleged violations involving abuse were reported immediately to the Administrator of the facility and to State Agencies in accordance with state law. In addition, the facility failed to have an effective system to ensure residents were protected after an allegation of abuse for one (1) of fifteen (15) sampled residents (Resident #1).</p> <p>An allegation of abuse involving Resident #1 was not reported immediately to the Administrator of the facility, and therefore not reported immediately to State Agencies. In addition, the facility failed to conduct a thorough investigation and failed to protect the residents from further potential abuse while the investigation was in progress.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Policy, undated, revealed any alleged violations involving mistreatment, neglect or abuse must be reported to the Administrator. "The Charge nurse will promptly start the investigation and immediately notify the Administrator. The facility Administrator shall immediately notify, their State Adult Protective Services Agency and their state</p>	F 225	<p>constitute willfulness on behalf of the employees in question.</p> <p>On 7/20/12, LPN #3 was educated by the Administrator regarding the importance of following facility policy as outlined in the Resident Advocacy Protocol Manual. This nurse also received additional education regarding the importance of ensuring resident safety immediately following any allegations of mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, and during any pending internal investigation.</p> <p>On 8/8/12 and 8/9/12, all charge nurses received additional education regarding the importance of following facility policy as outlined in the Resident Advocacy Protocol Manual. This included additional education regarding the importance of ensuring resident safety immediately following any allegations of the above noted items and the continued safety during any pending internal investigation.</p> <p>The Administrator and the Administrator-In-Training (AIT) received additional education by the Regional Continued Quality Improvement Nurse on 7/20/12 & 7/23/12 regarding the</p>	

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F 225	<p>Continued From page 2</p> <p>licensing agency of the suspected occurrence and others as required by regulation." Further review revealed, "employees of the facility that have been accused of resident abuse will be suspended from working pending an internal investigation".</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident with a diagnosis of Mental Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/22/12, revealed the facility assessed the resident as having both long and short term memory loss and as having moderate impairment in cognitive skills for decision making. Further review revealed the facility assessed the resident as requiring extensive assistance of two staff with bed mobility and transfer.</p> <p>Review of the Comprehensive Plan of Care, with a problem onset date of 11/17/11, revealed the resident required extensive assistance of two (2) staff for bed mobility, and transfers due to decreased functional status. Further review revealed the resident had difficulty recalling recent events and was at risk for further cognitive decline related to a diagnosis of Dementia. The interventions included approaching the resident from the front in a calm, unhurried manner.</p> <p>Review of the Nursing Note, dated 05/16/12 at 6:30 AM and completed by Licensed Practical Nurse (LPN) #3, revealed the Note was a late entry for 05/15/12 at 9:00 PM. The Note stated, this nurse was doing resident's bedtime finger stick and the resident stated, the Certified Nursing Assistant (CNA) who had put her/him to bed hit her/his head on the arm of the chair which</p>	F 225	<p>importance of following the facility policies listed in the Resident Advocacy Manual in relation to reporting requirements, resident safety, and thorough investigation.</p> <p>All incident reports, complaint/concern forms, and nursing report for the last 60 days have been reviewed by the Director of Nursing/RN Supervisor on 8/1/12 to determine that any incidents that may meet reporting criteria have been identified.</p> <p>All residents who can communicate will be interviewed to ensure that residents are comfortable, feel safe, and would feel free to verbalize any concerns to facility staff. This will be completed by August 31, 2012 by the Social Services Coordinator.</p> <p>The Social Services Coordinator will interview a minimum of 4 residents per week for 6 weeks to ensure they continue to feel safe, be comfortable and feel free to verbalize any concerns to staff. All incident reports, complaint/concern forms and nursing report will be reviewed daily (M-F) in the morning meeting to ensure that any incident meeting the criteria for reporting is identified and notification</p>	

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STREET ADDRESS, CITY, STATE, ZIP CODE

**RT 32 EAST, HOWARD CREEK RD
SANDY HOOK, KY 41171**

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F 225	<p>Continued From page 3</p> <p>was beside the bed. Further review revealed the nurse checked the resident's head and no red areas were noted. According to the Note, the resident continued to complain that the CNA was rough with her/him and complained she/he hit her/his forehead on the chair. The Note stated the nurse questioned the CNAs and one of the CNAs stated, "yes, she did hit the residents head on the chair arm", and stated that the resident's head barely brushed the arm of the chair.</p> <p>Review of the facility "Incident Report" revealed an incident was reported 05/16/12 related to the resident transferring to the bed from the chair. This was signed by LPN #3, CNA #14, the Director of Nursing (DON) and the Administrator on 05/17/12.</p> <p>Review of the Incident Investigation Report signed by LPN #3, on 05/17/12, revealed the resident was transferring from the chair to the bed and hit her/his head on the chair that sits next to the bed. The Report stated the witnesses were CNA #14 and CNA #15. The corrective action section stated: decrease in functional status with left sided weakness related to previous stroke. Further review revealed the facility would do three (3) day charting to monitor condition, and observation of mental status.</p> <p>Review of the statement obtained from CNA #14, on 05/16/12, revealed she and CNA #15 were transferring the resident to bed from the chair and the resident was on the side of the bed. CNA #15 had the resident's top half of the body and CNA #14 had her/his legs. When CNA #14 moved the resident's legs up on the bed, CNA #15's hand slid off of the residents head. The resident stated</p>	F 225	occurs as per facility policies. The results of the interviews and reviews will be evaluated in the monthly Quality Improvement Committee meeting for continued compliance.	

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F 225	<p>Continued From page 4</p> <p>"you hit my head".</p> <p>Review of the statement obtained from CNA #15, on 05/16/12, revealed she and CNA #14 were putting the resident to bed. CNA #15 had her hand on the resident's back and was supporting the resident's head and CNA #14 had the resident's legs. When CNA #14 moved the resident's legs up to the bed, CNA #15's hands slipped. The resident complained, "oh, my head". The resident was asked if she/he hit her head and she/he replied yes.</p> <p>A section of the Abuse Policy, labeled "Definitions" was attached to the investigation. The definition of abuse per the policy, revealed, "abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual". A handwritten note from the Administrator was noted on the attached policy, which stated the incident was not willful-lost control of the transfer.</p> <p>Interview with Resident #1 on 07/20/12 at 1:05 PM, revealed the staff treated her/him good. She/he stated CNA #14 and CNA #15 "never aimed to hurt me and don't treat me rough". Further interview revealed there was a problem during a transfer and she/he brushed her/his head which was an accident.</p> <p>Several attempts were made to reach CNA #14 and CNA #15 by phone on 07/20/12, however the CNA's were unable to be reached for interview.</p> <p>Interview on 07/19/12 at 4:20 PM with LPN #3</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>revealed Resident #1 stated CNA #14 and CNA #15 were rough when assisting her/him to bed and LPN #3 had questioned the CNAs' who explained the resident hit her/his head during the transfer from the chair to the bed, and they denied being rough with the resident. She stated she checked the resident and there was no red areas on the resident's head. Continued interview revealed she was to report any allegations of abuse to the Administrator immediately; however, did not feel this was an allegation of abuse because she felt it was an accident and there was no injury. She stated she reported it immediately to the RN Supervisor the next morning on 05/16/12 at about 7:00 AM.</p> <p>Interview on 07/20/12 at 1:10 PM with Registered Nurse (RN) #3 /Supervisor, revealed the morning of 05/16/12 LPN #3 had notified her of Resident #1 hitting her/his head during the transfer and of the interviews she conducted with the CNA's. She stated she brought it up in the morning meeting on 05/16/12 and felt it was an accident; however, she stated she was unaware of the resident accusing the CNA's of being rough.</p> <p>Interview on 07/20/12 at 10:30 AM, 3:15 PM and 3:45 PM, with the Administrator revealed she was notified of the event in the morning meeting on 05/16/12 and initially questioned why she was not notified immediately of the incident because she had educated staff if there was a suspicion of abuse they were to notify her immediately. However, after reviewing the information in the morning meeting, she felt staff lost control during a transfer and this was not willful. Continued interview revealed further interview was not conducted with this resident because LPN #3 had</p>	F 225		

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F 225	Continued From page 6 received the statement and transcribed it into the Nursing Note dated 05/16/12. She also verified CNA #14 and CNA #15 were not removed from duty during the investigation. She stated, if there was an allegation of abuse, staff were to report to her immediately and she would report to the state agencies. Further interview revealed the perpetrators would be suspended pending investigation and a thorough investigation would be completed which would include interviewing the perpetrator, resident, resident's family, resident's roommate, and staff involved. She stated the facility had not followed through with removing the perpetrators from duty and reporting the incident to State Agencies because staff was to suspect abuse before reporting it.	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure Physician's Orders were followed for one (1) of fifteen (15) sampled residents (Resident #6). Resident #6 had Physician's orders to notify the Physician if Resident #6 received less than three hundred sixty (360) cubic centimeters (cc's) of Pulmocare (Enteral Formula) during a twelve (12) hour shift; however, there was no documented evidence the Physician was notified when the resident failed to receive the specified amount on thirteen (13) different shifts in 07/12.	F 281	It is the policy of Elliott Nursing & Rehabilitation Center (ENRC) that services provided or arranged by the facility must meet professional standards of quality. The Medical Director was consulted on 7/18/12 and stated that due to the patient's current medical condition, notification for this order was not necessary at this time and MD notification should be removed from the order. On 7/18/12 the order for Resident #6 was changed to omit MD notification. Physician's Orders for all residents have been reviewed by DON/RN Supervisor/Charge Nurse for all current	8/31/12

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F 281	<p>Continued From page 7</p> <p>The findings include:</p> <p>Interview, on 07/20/12 at 5:05 PM, with the Quality Assurance (QA) Director, revealed the facility did not have a policy regarding following Physician's orders. She stated, following Physician's orders was an expectation based on nursing standards of practice.</p> <p>Record review revealed the facility readmitted Resident #6 on 02/28/11, with diagnoses which included Hypoxemia, Food/Vomit Pneumonitis, Dysphagia, Anemia, Mental Disorder, Psychosis, and Hypertension. Review of the Annual Minimum Data Set (MDS) Assessment, dated 04/25/12, revealed the facility assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment.</p> <p>Review of the Physician's orders, dated July 2012, revealed orders to notify the Physician if Resident #6 received less than three hundred sixty (360) cubic centimeters (cc's) of Pulmocare (Enteral Formula) during a twelve (12) hour shift.</p> <p>Review of the Medication Administration Record (MAR), dated July 2012, revealed thirteen (13) different shifts when Resident #6's total intake of Pulmocare was less than three hundred sixty (360) cc's for the previous twelve (12) hours which included: 07/01/12 PM shift, 07/03/12 AM shift, 07/04/12 AM shift, 07/07/12 AM and PM shifts, 07/08/12 AM shift, 07/09/12 AM and PM shifts, 07/10/12 AM shift, 07/11/12 AM shift, 07/12/12 AM and PM shift, and 07/14/12 AM shift.</p>	F 281	<p>residents and then reviewed again by DON/RN Supervisor/Charge Nurse no later than 8/31/12 to ensure that physician's orders have been noted and implemented as written by the Physician.</p> <p>Education will be provided to all licensed nursing staff by 8/31/12 regarding the importance of following physician's orders as directed including notification of physician by the DON/RN Supervisor.</p> <p>The DON/RN Supervisor will review at least 10 physician's orders per week for 4 weeks to ensure that the order has been received, noted and implemented as directed by the physician.</p> <p>The results of these audits will be forwarded to the monthly Quality Improvement Committee for further monitoring and continued compliance.</p>	

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F 281	<p>Continued From page 8</p> <p>However, review of the Nurses Notes revealed no documented evidence the Physician was notified when the resident failed to receive the specified amount.</p> <p>Interview, on 07/18/12 at 3:50 PM, with Licensed Practical Nurse (LPN) #2, confirmed the Physician's orders, dated July 2012, indicated to notify the Physician when the total intake in a twelve (12) hour shift was below three hundred sixty (360) cc's; however, there were no documented evidence the Physician was notified when the total intake of Pulmocare per twelve (12) hour shift was less than three hundred sixty (360) cc's.</p> <p>Interview, on 07/18/12 at 4:00 PM, with Registered Nurse (RN) #1, revealed there was no documented evidence the Physician was notified of Resident #6 receiving less than three hundred sixty (360) cc's on thirteen (13) different occasions.</p> <p>Interview, on 07/18/12 at 4:20 PM, with the Director of Nursing, revealed the Physician's order should have been followed regarding Resident #6's amount of intake of Pulmocare in a twelve (12) hour shift.</p> <p>Interview, on 07/18/12 at 4:15 PM, with the Medical Director, revealed the order should have been followed to notify the Physician if Resident #6 did not receive the ordered amount of Pulmocare in a twelve (12) hour shift.</p>	F 281		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident</p>	F 323	<p>It is the policy of Elliott Nursing and Rehabilitation Center (ENRC) to ensure that the resident environment remains as free of accident hazards as possible; and</p>	8/31/12

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F 323	<p>Continued From page 9</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure residents' environment remained as free from accidents and hazards as is possible. Observation during the survey of water temperatures in residents' rooms revealed the temperatures measured between 118 degrees Fahrenheit (F) to 126 degrees F. In addition, the facility's policy: "Hot Water Testing & Regulation" failed to comply with the maximum hot water temperature of 110 degrees F identified in State Regulation 902 KAR 20:310-16(5)(g).</p> <p>The findings include:</p> <p>Review of the facility's policy "Hot Water Testing & Regulation", dated 01/01/95, revealed the facility hot water testing and regulating requirements for resident rooms, a) should not be below 105 degrees F and not go above 115 degrees F, and b) should temperatures get outside of acceptable temperatures, corrective steps should be taken immediately.</p> <p>Review of Kentucky State Regulation, 902 KAR 20:310-16 (5)(g), revealed the Plumbing fixtures which require hot water and which are intended</p>	F 323	<p>each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Steps were taken by the Maintenance Director to immediately reduce the water to a lower temperature on 7/17/12.</p> <p>On 7/23/12, the policy was changed by the Administrator to reflect a maximum temperature of 110 degrees for any water intended for patient use.</p> <p>The Maintenance Director was educated on 7/23/12 regarding the updated water temp policy indicating that all water intended for resident use should be at a maximum of 110 degrees by the Administrator. Also, that if any temperature above the maximum is identified corrective steps should be taken immediately and the Administrator or Administrator-in-training (AIT) should be notified.</p> <p>New mixing valves and new hot water heater were ordered 8/6/12 by the Administrator-In-Training.</p> <p>An Environmental/Accident Hazards audit was conducted by the Maintenance Director with the Regional Maintenance Supervisor on 7/20/12 to identify any</p>	

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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
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F 323	<p>Continued From page 10</p> <p>for patient use shall be supplied with water which is controlled to provide a maximum water temperature of 110 degrees Fahrenheit at the fixture.</p> <p>Review of the facility's Weekly Hot Water Temperature Log Sheet for June 2012 revealed on 06/19/12 the facility recorded the following maximum hot water temperatures above 110 degrees F: room 102 = 115.2 degrees F, Room 111 = 112.3 degrees F, Room 204 = 114.4 degrees F, Room 209 = 111.7 degrees F and listed showers = 114.3 degrees F. No plan of correction was documented.</p> <p>Further review of the June 2012 Weekly Hot Water Temperature Log Sheet revealed on 06/26/12 the following maximum hot water temperatures above 110 degrees F were recorded: Room 104 = 114.7 degrees F, Room 109 = 113.4 degrees F, Room 206 = 114.8 degrees F, Room 211 = 112.9 degrees F, Room 302 = 111.4 degrees F, and Room 307 = 112.8 degrees F. No plan of correction was documented.</p> <p>Review of the facility's Weekly Hot Water Temperature Log Sheet for July 2012 revealed on 07/05/12 the following maximum hot water temperatures above 110 degrees F were recorded: Room 104 = 115.2 degrees F, Room 109 = 114.7 degrees F, Room 206 = 114.3 degrees F, Room 209 = 113.6 degrees F, and Room 302 = 111.3 degrees F.</p> <p>Further review of the July 2012 Weekly Hot Water Temperature Log Sheet revealed on 07/10/12 the following maximum hot water temperatures</p>	F 323	<p>areas of further concern. All identified issues have been addressed.</p> <p>The Maintenance Director will check water temperatures at least 3 times per week for 4 weeks at different times of the day in different areas in the facility to ensure compliance. The temperatures will be documented on the maintenance log.</p> <p>The Administrator/Administrator-In-Training will complete and Environmental/Accident Hazards audit weekly for 4 weeks to identify any areas noted to need improvement. The Administrator/AIT will also audit the Maintenance Directors log and do random checks of water temperatures.</p> <p>The results of these audits/logs will be forwarded to the monthly the Quality Improvement Committee and the Safety Committee for further review and continued compliance.</p>	

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F 323	<p>Continued From page 11</p> <p>above 110 degrees F were recorded: Room 104 = 115.2 degrees F, Room 109 = 114.7 degrees F, Room 206 = 114.3 degrees F, Room 209 = 113.6 degrees F, and Room 302 = 111.3 degrees F.</p> <p>Observation, on 07/17/12, revealed the following maximum hot water temperatures were identified: 3:30 PM Room 107 = 112 degrees F; 3:50 PM Room 111 = 112 degrees F; 6:10 PM Room 302 = 126 degrees F (the temp dropped to 112 degrees F after approximately 15-20 seconds) and Room 309 = 118 degrees F.</p> <p>Additional observation with the Maintenance Supervisor, on 07/17/12 at 6:40 PM, revealed the maximum hot water temperatures were initially measured as follows (before dropping down below 110 degrees F after a few seconds): in Room 309 = 123 degrees F, in Room 302 = 126 degrees F and in Room 408 initially measured at 114 degrees F.</p> <p>Interview, on 07/17/12 at 6:45 PM, with the Maintenance Supervisor, revealed he did weekly hot water checks, but had been checking several rooms almost daily due to concerns with regulating the maximum hot water temperature. He stated, he did not record the daily temperatures. Further interview revealed the maximum water temperature should be "about 115 degrees F or below 110 degrees F". In addition, he stated he did not check the thermometer for accuracy because "you can't calibrate this kind of thermometer".</p> <p>Observation of the water temperatures in resident rooms on 07/18/12 revealed: at 8:53 AM Room 309 = 114 degrees F; at 09:05 AM Room 204 =</p>	F 323		

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F 323	Continued From page 12 112 degrees F; and at 9:25 AM Room 408 = 112 degrees F. Interview, on 07/20/12 at 5:45 PM, with the Administrator revealed the maximum water temperature should not be above 115 degrees F and not below 105 degrees F. She stated, the Maintenance Director had reported he had trouble regulating the temperatures. She further stated the Maintenance Director had a weekly log and also did an informal daily check of temperatures and was timely about making adjustments if any problems. Further interview revealed they were unable to determine what the problem was with keeping the temperature within the proper range at all times. She stated, maximum hot water temperature controls were for the safety of the residents.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to store food under sanitary conditions as evidenced by no thermometer in the freezer on	F 371	It is the policy of Elliott Nursing & Rehabilitation Center (ENRC) that we procure food from sources approved or considered satisfactory by Federal, State or local authorities and that food be stored, prepared, distributed and served under sanitary conditions. A thermometer was added to the freezer identified in the Lighthouse on 7/17/12 by the Dietary Manager. Nurse #1 was educated on 7/17/12 by the Dietary Manager regarding the Frozen Storage Policy and the necessity of a thermometer in all freezer and proper documentation and temperature ranges.	8/31/12

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F 371	<p>Continued From page 13 the Lighthouse unit.</p> <p>The findings include:</p> <p>Review of the facility's policy "Frozen Storage", undated, revealed the facility would store, prepare and serve food in accordance with federal, state and local sanitary codes. Further review revealed "Every freezer will be equipped with a visable thermometer".</p> <p>Observation, on 07/17/12 at 11:40 AM, revealed the freezer of the refrigerator on the Lighthouse unit did not have a thermometer in place. The freezer contained six (6) bowls labeled "chicken soup" dated 07/16/12, seven (7) popsicles, and a bag of ice.</p> <p>Interview, on 07/17/12 at 5:05 PM, with Licensed Practical Nurse (LPN) #1 revealed she was not aware of the facility's policy on thermometers in the freezer. He/She stated, "I would think, just like at home, if it felt frozen, it would be okay".</p> <p>Interview, on 07/17/12 at 5:45 PM, with the Certified Dietary Manager (CDM) and the Registered Dietician revealed the freezer should have a thermometer in it.</p>	F 371	<p>On 7/17/12 the Dietary Manager audited all facility freezer and refrigerators to ensure that thermometers were in place and logs are complete.</p> <p>All Nurses will be educated by 8/31/12 by the Dietary Manager/DON/RN Supervisor regarding the Frozen Storage Policy and the necessity of a thermometer in all freezer and proper documentation and temperature ranges.</p> <p>All freezer/refrigerators will be audited for 4 weeks by the Dietary Manager to ensure thermometers are present and temperatures are documented on the log.</p> <p>Results of audits forwarded to CQI committee for further review and continued compliance.</p>	
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically</p>	F 431	<p>It is the policy of Elliott Nursing & Rehabilitation Center (ENRC) to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order is maintained and periodically reconciled.</p>	8/31/12

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F 431	<p>Continued From page 14 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>	F 431	<p>Drugs and biological used in the facility must be labeled in accordance with currently accepted professional principles, and cautionary instructions, and the expiration date when applicable.</p> <p>On 7/18/12, all medications opened but not dated were removed from use by the Director of Nursing.</p> <p>On 7/18/12, all medications were audited by the consultant pharmacist and DON to ensure that all drugs or biological were properly dated.</p> <p>All licensed nursing staff will be educated by the Director of Nursing regarding the proper dating of all drugs and/or biological medications by 8/31/12.</p> <p>All medications will be audited by our pharmacy representative monthly for proper dating of all medications. The DON/RN Supervisor will audit the medication room, med carts, and treatment carts for 4 weeks to ensure all medications are appropriately dated. Thereafter the DON/designee will perform monthly audit of all medications to ensure continued compliance.</p> <p>Results of audits will be forwarded to Quality Improvement committee for further review and continued compliance.</p>	

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F 431	<p>Continued From page 15</p> <p>Observation of the medication cart and treatment cart revealed medications and biologicals which were opened and undated.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Medication Storage in the Facility", undated, revealed "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier."</p> <p>Observation, on 07/18/12 at 9:30 AM, of the medication cart revealed an Advair Diskus Inhaler which was opened with no date. Interview with Registered Nurse at the time of the observation revealed the Advair Diskus Inhaler should have been dated when opened.</p> <p>Observation, on 07/18/12 at 10:30 AM, of the treatment cart revealed a bottle of Normal Saline solution and a bottle of Acetic Acid 0.25% Irrigation solution were opened with no date on the bottles. Interview with Registered Nurse (RN) #1 at the time of the observation revealed the bottles should have been dated when opened.</p> <p>Interview, on 07/18/12 at 10:30 AM, with the Pharmacist revealed Normal Saline solution was good for twenty-four (24) hours after opening and Acetic Acid was good for thirty (30) days after opening.</p> <p>Interview, on 07/25/12 at 2:15 PM, with the Director of Nursing (DON) confirmed the nurses and Certified Medical Technicians (CMTs) were to date medications and biologicals when they</p>	F 431		

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F 431	Continued From page 16 opened them. When asked if there was any checks of the medication carts to ensure proper storage and labeling of medications and biologicals, she stated the nurses and CMTs were responsible for checking this with use of the carts.	F 431		
F 441 SS=E	<p>483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>It is the policy of Elliott Nursing & Rehabilitation Center (ENRC) to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>On 7/23/12, the Director of Nursing re-educated RN #2, CNA #13, LPN #6, LPN#3, LPN#2, CNA #1 regarding proper hand washing per the Infection Control policies. CNA # 1 was reeducated regarding positioning of the ice scoop per the Infection Control Policy.</p> <p>All nursing staff will be reeducated regarding proper hand washing before, during, and after personal and incontinence care per the Infection Control Policies. This reeducation includes review of proper infection control techniques and review of information obtained on the CDC website. This reeducation will be provided by the DON/RN Supervisor and be completed by 8/31/12.</p>	8/31/12

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F 441	<p>Continued From page 17</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policies, it was determined the facility failed to 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 for three (3) of fifteen (15) sampled residents (Resident #1, #3 and #4).</p> <p>Observation on initial tour revealed a nurse placed the nasal cannula in Resident #3's nostrils with her bare hands and exited the room without washing her hands.</p> <p>Observation of incontinence care for Resident #3 revealed staff failed to wash hands after performing incontinence care and prior to touching objects in the room. Staff also failed to wash hands prior to exiting the room after the incontinence care.</p> <p>Further observation of Resident #3 revealed a nurse performed incontinence care and then without washing her hands performed a dressing change.</p>	F 441	<p>All nursing staff will be reeducated by the DON/RN Supervisor regarding proper use and positioning of the ice scoop per the Infection Control Policies to avoid the possibility of cross contamination by 8/31/12.</p> <p>The DON/RN Supervisor will visually monitor via daily compliance rounds (Monday- Friday) various aspects of the infection control program at least 3 times per week for 4 weeks and once a month ongoing.</p> <p>In addition, the DON/RN Supervisor will complete random observation of hand washing before, during, and after personal and incontinence care per the Infection Control Policies and proper use of the ice scoop. Any violation will be addressed with one-on-one education.</p> <p>The results of the daily compliance rounds and the random observations will be forwarded to the monthly Quality Improvement committee meeting for further review and continued compliance.</p>	

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F 441	<p>Continued From page 18</p> <p>Observation of perineal care for Resident #1 and Resident #4 revealed poor infection control technique.</p> <p>In addition, observation further revealed staff were repeatedly placing the ice scoop back inside the ice chest, on top of the ice during ice pass.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Infection Control", dated 09/99, revealed the objectives of the infection control policies and procedures included; preventing and controlling the spread of communicable/contagious diseases and maintaining a sanitary environment for personnel, residents, visitors, and the general public.</p> <p>Review of the facility's policy entitled "Handwashing and Hand Hygiene", dated 12/01/10, revealed handwashing or the use of alcohol-based hand rubs was recognized as the most basic yet most effective means of preventing and controlling the spread of infection. Further review revealed hand hygiene was indicated before and after contact with a resident, after touching a source that is likely to be contaminated, such as soiled linens, after touching excretions such as feces, urine, or material soiled with them, and before and after changing an incontinent resident.</p> <p>Review of the facility's policy entitled "Incontinent Resident Care", dated 02/01/12, revealed staff was to wash, rinse, and dry the buttocks area, wash hands, change gloves, apply barrier cream if indicated, wash hands, apply gloves, position the resident, replace the blanket and bedspread,</p>	F 441		

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F 441	<p>Continued From page 19</p> <p>remove gloves, wash hands, leave the signal cord in reach, and wash hands.</p> <p>A policy related to peri-care was requested, however, not received.</p> <p>1. Review of Resident #3's medical record revealed diagnoses which included Alzheimer's Dementia.</p> <p>Observation during initial tour, on 07/17/12 at 11:00 AM, revealed Registered Nurse (RN) #2 placed the oxygen nasal cannula into Resident #3's nostrils, and exited the room without washing her hands. She continued tour with the surveyor and went into Room 205. Interview with RN #2 during the initial tour at 11:15 AM, revealed she should have washed or sanitized her hands after handling the resident's nasal cannula.</p> <p>2. Observation of incontinence care for Resident #3 in Room 207, on 07/17/12 at 2:45 PM, revealed Certified Nursing Assistant (CNA) #13 cleansed stool from the resident's buttocks, removed the soiled gloves, and without washing or sanitizing her hands, opened the bedside table drawer and obtained a tube of Aloe Vesta Ointment. The CNA then donned new gloves and applied the Ointment to the resident's buttocks. Further observation revealed CNA #13, with the same soiled gloves positioned the call bell in reach of the resident, pulled the resident up in the bed and placed the soiled attends in a bag. CNA #13 then removed one glove and opened the door with the bare hand while holding the bag with the gloved hand, opened the door to the dirty utility and discarded the bag. She then left the dirty utility room and went to Room 201 to wash</p>	F 441		

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STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2012
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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
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 20 her hands.</p> <p>Interview, on 07/17/12 at 2:50 PM, with CNA #13 revealed she failed to wash her hands after cleansing stool from the resident's buttocks and prior to obtaining the Aloe Vesta Ointment from the drawer. She further acknowledged she had touched objects in the room with her gloved hands after applying Ointment to the resident's buttocks, and failed to wash her hands prior to exiting the resident's room.</p> <p>3. Observation of a dressing change for Resident #3 revealed Licensed Practical Nurse (LPN) #6 wiped stool from the resident's buttocks with a wet wipe, removed her gloves, and without washing her hands donned new gloves. She then cleansed the resident's wound to the coccyx with a Normal Saline soaked guaze, applied CombiDERM dressing, removed her gloves and washed her hands.</p> <p>Interview, on 0/18/12 at 3:30 PM, with LPN #6 revealed she should have washed her hands after cleansing the resident's buttocks and prior to performing the dressing change.</p> <p>4. Observation of perineal care for Resident #1 on 07/18/12 at 2:55 PM, revealed Licensed Practical Nurse (LPN) #3 cleansed the resident's buttocks with wet wipes, repositioned the resident to his/her back, and then without washing her hands and changing gloves, proceeded to cleanse the resident's vaginal area. She then removed her gloves, and without washing her hands, opened the closet door and retrieved a pair of pants for the resident. After assisting the resident with donning the pants, she then washed</p>	F 441		

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F 441	<p>Continued From page 21 her hands.</p> <p>Interview, on 07/18/12 at 3:05 PM with LPN #3, revealed she should have cleansed the vaginal area first, prior to cleansing the buttocks or washed hands after cleaning the buttocks and prior to cleansing the vaginal area. Continued interview revealed she should have washed her hands after completing incontinence care and prior to touching objects in the rooms such as the closet door.</p> <p>5. Observation of perineal care for Resident #4, on 07/18/12 at 3:10 PM, revealed LPN #2 cleansed the resident's buttocks as the resident was positioned on his/her side, then proceeded to reposition the resident to the back. She then, with the same soiled gloves, cleansed the resident's penis and scrotum, removed her gloves and sanitized her hands.</p> <p>Interview, on 07/18/12 at 3:25 PM, with LPN #2 revealed she should have washed hands and donned new gloves after cleansing the resident's buttocks and prior to cleaning the resident's genitals.</p> <p>6. Observation, on 07/17/12 at 11:30 AM, revealed a chest containing ice with a scoop inside on top of the ice. Further observation revealed CNA #1 repeatedly scooped ice into the residents water pitchers and then placed the scoop back inside the ice chest on top of the ice for residents on the 300 hall.</p> <p>Interview with CNA #1, on 07/17/12 at 12:30 PM, revealed the scoop was not supposed to be kept inside the ice chest and was to be kept outside.</p>	F 441		

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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
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F 441	<p>Continued From page 22</p> <p>the chest in a scoop holder. The CNA stated the scoop was to be placed into the scoop holder after scooping ice into the residents' water pitchers. Further interview revealed the scoop was to be kept outside of the ice chest when not in use to prevent cross contamination.</p> <p>Interview with Registered Nurse (RN) #1, on 07/20/12 at 12:40 PM, regarding the use of the ice chest scoop when filling ice in the residents' water pitchers, revealed when the scoop was not in use, it should be placed in a plastic bag outside of the ice chest. Further Interview revealed the scoop should not be kept in the ice chest because if the handle of the scoop came in contact with the ice there could be cross contamination.</p> <p>Interview, on 07/20/12 at 4:30 PM, with the Director of Nursing (DON) and Registered Nurse (RN) #1/Staff Development Coordinator, revealed the supervisors and nurses observed staff randomly during daily rounds related to infection control issues while providing care. The DON stated RN #1 and other nurses informed her of any infection control concerns identified and education was completed with the Ward Meetings on the units and also one (1) on one (1) with the staff involved. RN #1 stated she observed CNAs to perform perineal care, and also rounded the units several times a shift at least 3 days a week to watch for infection control issues. She stated some of her audits were recorded on an audit form and some were casual. Continued interview revealed if she noticed a trend she would inservice all staff related to the infection control concern.</p>	F 441		
F 520	483.75(o)(1) QAA	F 520	Next page.	

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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
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F 520 SS=E	<p>Continued From page 23 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to</p>	F 520	<p>It is the policy of Elliott Nursing & Rehabilitation Center to maintain a Quality Assessment and Assurance Program that develops and implements appropriate plans of action to correct quality deficiencies.</p> <p>On 8/22/12, the Regional Quality Improvement Nurse will educate all members of the Quality Improvement Committee regarding proper development, implementation and follow-up of action plans. She will also discuss the importance of follow-up on all identified deficiencies to ensure these issues are resolved.</p> <p>On 8/01/12, all CQI minutes including action plans beginning January 2012 to current were audited by the Administrator and the Quality Improvement Committee Chairman to ensure that appropriate action plans were initiated based upon tracking and trending of identified issues. Action Plans were also reviewed to ensure that appropriate follow-up was completed until the problems resolved.</p> <p>Effective 8/01/12, the Quality Improvement Committee will continue to follow-up on any action plan until the problem has proved to be resolved for a minimum of 6 weeks.</p>	8/31/12
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NAME OF PROVIDER OR SUPPLIER ELLIOTT NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD OREEK RD SANDY HOOK, KY 41171
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F 520	<p>Continued From page 24</p> <p>ensure there was an effective infection control program, and failure to ensure supervision to prevent accidents.</p> <p>The findings include:</p> <p>1. Based on observation, interview, and record review, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and infection within the facility. This was a repeat deficiency for the facility which was cited 05/20/11 related to staff administering medications after touching pills with bare hands, poor infection control related to peri-care, and poor infection control during a dressing change/wound treatment.</p> <p>Review of the facility's Plan of Correction, with a compliance date of 06/30/11, revealed nursing management would conduct inservices for all nursing staff on the importance of maintaining an Infection Control Program and providing care and services in such a manner as to prevent the development and transmission of disease and infection. The facility alleged the Director of Nursing (DON) or designee would visually monitor via daily compliance rounds Monday thru Friday various aspects of the infection control program three (3) times per week for four (4) weeks to include medication administration, handwashing, gloving, linen handling, dressing changes, perineal care and catheter care.</p> <p>Observations during the survey revealed the following: Observations for Resident #3 revealed a nurse placed the nasal cannula in the residents nostrils with her bare hands and failed to wash</p>	F 520	<p>Effective 8/01/12, any resolved action plans will be added to the annual Quality Improvement Committee calendar for annual follow-up by observation and/or audit of the identified issue to ensure ongoing compliance.</p>	

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F 520	<p>Continued From page 25</p> <p>her hands prior to exiting the room. Further observation for Resident #3 revealed staff failed to wash hands after performing incontinence care and prior to touching objects in the room, and failed to wash hands prior to exiting the room after the incontinence care. In addition, observation for Resident #3 revealed a nurse performed incontinence care and failed to wash her hands prior to performing a dressing change.</p> <p>Also, observation of perineal care for Resident #1 and Resident #4 revealed poor infection control technique.</p> <p>In addition, observation revealed staff were repeatedly placing the ice scoop back inside the ice chest, on top of the ice during ice pass.</p> <p>Interview, on 07/20/12 at 4:00 PM, with the Quality Assurance Director revealed the DON had ensured inservice education was provided related to Infection control and conducted rounds to observe infection control practices.</p> <p>Interview, on 07/20/12 at 4:30 PM with the DON, and the Staff Development Nurse, revealed there had been inservices and return demonstrations related to peri-care since the last standard survey and there was continued informal audits of perineal care, skin assessments and dressing changes being conducted. Further interview revealed the nursing supervisors continued to do daily rounds to observe for infection control concerns; however, it was random and there was no formal audits at this time. The DON stated, she would need to emphasize with staff the need to wash hands prior to changing gloves.</p>	F 520		

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F 520	<p>Continued From page 26</p> <p>2. Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure residents' environment remained as free from accidents and hazards as is possible. This was a repeat deficiency for the facility which was cited 05/20/11 related to central shower rooms having numerous toiletries left out on the counter tops, and water temperatures in residents' rooms and a shower room measured between 113.9 degrees Fahrenheit (F) and 126.0 degrees F.</p> <p>Review of the facility's Plan of Correction, with a compliance date of 08/30/12, revealed the DON or designee educated all staff regarding the importance of maintaining an environment that remains as free of accident hazards as is possible, and the Maintenance Director received additional education by the Administrator regarding the importance of maintaining the hot water temperatures within the acceptable range and to ensure coverage for scheduled checks if he was going to be out of the facility. Also, the POC specified the Administrator or designee would complete an Environmental Accident Hazards audit weekly for four weeks to identify any areas needing improvement, and the Maintenance Director would audit hot water temps at least three (3) times per week for four (4) weeks at different areas of the facility.</p> <p>Observation during this survey revealed water temperatures in residents' rooms measured between 118 degrees Fahrenheit (F) to 126 degrees F. In addition, the facility's policy: "Hot Water Testing & Regulation" failed to comply with the maximum hot water temperature of 110 degrees F identified in State Regulation 902 KAR</p>	F 520		

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F 520	<p>Continued From page 27 20:310-16(5)(g).</p> <p>Interview, on 07/17/12 at 6:45 PM, with the Maintenance Supervisor, revealed he obtained weekly hot water checks, and In addition had been checking several rooms almost daily due to concerns with regulating the maximum hot water temperature. He verified, he did not record the daily temperatures. Continued interview reveled the maximum water temperature of the water should be "about 115 degrees F or below 110 degrees F". Additionally, he stated he did not check the thermometer for accuracy because "you can't calibrate this kind of thermometer".</p> <p>Interview, on 07/20/12 at 5:45 PM, with the Administrator, revealed the water temperature should not be above 115 degrees F and not below 105 degrees F. She was aware the Maintenance Director had trouble regulating the water temperatures. She verified, the Maintenance Director had a weekly log and also did an informal daily check of temperatures and was timely about making adjustments if any problems; however, they were unable to determine what the problem was with keeping the temperature within the proper range at all times.</p>	F 520		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - LOCK DOWN UNIT B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2012
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)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 2009</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story , Type V (000)</p> <p>Smoke Compartment: Three (3)</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, heat detectors in HVAC of Light House Unit. Upgraded panel in 2009</p> <p>Sprinkler System: Complete sprinkler system (DRY).</p> <p>Generator: Type 2 generator powered by diesel</p> <p>A standard Life Safety Code survey was conducted on 07/18/12. Elliot Nursing and Rehabilitation Center (Light House Unit) was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was seventy one (71). The facility is licensed for seventy five (75) beds.</p>	K 000		

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

TITLE

(X6) DATE

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