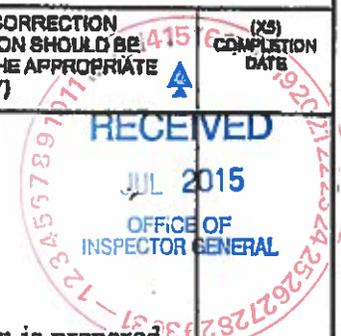


**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 07/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2015
NAME OF PROVIDER OR SUPPLIER HOPKINS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 480 SOUTH COLLEGE STREET WOODBURN, KY 42170	
(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	F 000		
F 226 SS=D	<p>A Recertification Survey was conducted on 06/21/15 through 06/23/15 with deficiencies cited at the highest Scope and Severity of an "E".</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of employee personnel files, and review of facility policy, it was determined the facility failed to implement written policies that prohibit mistreatment, neglect, and abuse of residents as evidenced by one (1) of seven (7) employee files reviewed failed to contain a pre-employment Criminal Background Check (Employee #1).</p> <p>The findings include:</p> <p>Review of the facility "Abuse Policy", undated, revealed background checks, to include Nurse Aide Abuse Registry checks, were to be completed prior to employees working at the facility.</p> <p>Review of Employee #1's Personnel Record revealed the employee was hired on 03/01/15; however, there was no documented evidence a Criminal Background Check was completed on or prior to the date of hire.</p>	F 226	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hopkins Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>Upon discovery the Human Resources Assistant requested a new background screening for Employee # 1. The completed background check was received on June 23, 2015.</p> <p>All residents of the facility have the potential to be affected. The Human Resource Assistant conducted a full audit on June 23, 2015, to ensure that all employees are in compliance with their prescreening criminal background check process with corrective action if indicated.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Wendi Butler, Administrator* TITLE _____ (X8) DATE *07/14/15*

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 226	Continued From page 1 Interview with the Director of Nursing/ Abuse Neglect Coordinator, on 06/23/15 at 11:15 AM, revealed the background checks were to be completed on all employees prior to hire. She further stated the human resources/payroll staff goes through the background checks through a company. In addition, she stated the employee's criminal background check should have been in the file. Interview with the Human Resources/Payroll Personnel, on 06/23/15 at 10:35 AM, revealed a Criminal Background Check was completed but was not in the employees personnel file due to the facility allegedly not having access to the employees criminal background check on their system. She further explained the employee came from a sister facility and had transferred from another state to Kentucky and the sister facility told them the employee was clear to hire because the sister facility ran a criminal background check on the employee for their state. She further stated she was unable to run a background check through their system because she could not open it up due to the sister facility having him as an employee in their system. She revealed the Criminal Background Check should be in the employees file. Interview with the Administrator, on 06/23/15 at 10:35 AM, revealed she relied on her Human Resources/Payroll personnel to complete the criminal background checks and could not due to the system not allowing her staff to do so.	F 226	The Regional Vice President re-educated the Administrator on June 29, 2015, on the practice to ensure that all new hire and transferred-in employees will receive the appropriate background screenings prior to employment or being transferred in. The Administrator re-educated the Human Resource Assistant on June 29, 2015, on the appropriate background screening requirements. A post-test was completed on July 13, 2015 and graded by the Regional Vice-President to validate understanding. The Human Resources Assistant will review all further new hires and validate that they have the required criminal background screening on file. The Business Office Manager will audit all new hires for 30 days and then one new hire each week with corrective action upon discovery if indicated. The Human Resources Assistant will submit a summary of the findings to the monthly Quality Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Dietary Manager, and Maintenance Director, monthly x 3 months for further review and recommendations until the issue is resolved. July 24, 2015	07/24/15	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 2</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of the DO NOT CRUSH list and Potassium Chloride directions, it was determined the facility failed to ensure one (1) Unsampled resident (Resident A) not in the twelve (12) sampled residents, received the service that met professional standards of quality. Unsampled Resident A was administered crushed medications on 06/22/15 that included Potassium extended release that was not to be crushed.</p> <p>The findings include:</p> <p>Review of the facility policy and procedure titled, "Medication Administration; Oral, last revised 05/04/15, revealed to crush medications and mix with food as appropriate. Refer to Common Oral Dosage Forms that should not be crushed.</p> <p>Review of the Do Not Crush list, dated 2006, revealed extended release medication was designed to release drug over an extended period of time. Such products included "Mixed release pellets that dissolve at different time intervals and included Potassium Chloride (CL) Extended Release (ER).</p> <p>Review of Unsampled Resident A's June 2015 Physician's Orders revealed MAY CRUSH CRUSHABLE MEDICATIONS. The order included Potassium CL 10 MEQ (milliequivalents), give one (1) capsule by mouth one time a day related to Congestive Heart Failure.</p>	F 281	<p>Upon discovery the Assistant Director of Nursing (ADNS) re-educated RN # 1 on June 22, 2015 on the policy of Medication Administration: General and Oral and the Pharmacy's "do not crush list". A post-test will be given by the ADNS and completed to validate understanding. Upon discovery the physician was notified. Unsampled Resident A did not experience any negative outcome.</p> <p>All residents of the facility have potential to be affected. The Director of Nursing, Assistance Director of Nursing and/or the Pharmacy extender will audit medication passes until each Licensed Nurse and CMA have been observed and received compliance to ensure that the "do not crush" list is followed with corrective action upon discovery.</p> <p>The Licensed Nurses and Certified Medication Aids were re-educated on the Medication Administration policy and the pharmacy's "do not crush" list. The re-education began on June 22, 2015 and will finish by July 23, 2015. A post-test will be given by July 23, 2015, by the Assistant Director of Nursing to validate understanding.</p> <p>Four Licensed Nurses will be reviewed each week until each nurse receives compliance by the Director of Nursing, ADNS, or Pharmacy extender with corrective action upon discovery to ensure the "do not crush" list is followed.</p>	

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F 281	Continued From page 3 Review of the package directions for Unsampld Resident A's Potassium CL ER revealed "Swallow whole, do not chew or crush, take with plenty of water, avoid lying down for 10 minutes after taking. Take this medicine with a meal". Observation of a medication pass, on 06/22/15 at 8:40 AM, revealed Registered Nurse (RN) #1 pulled Unsampld Resident A's medications and placed them in a medication cup. The Potassium CL ER capsule was opened and the timed release pellets were placed in the medication cup. RN #1 then put all the medications into the clear plastic holder and crushed them. She then administered the medicallons mixed with applesauce to Unsampld Resident A. Interview with Registered Nurse (RN) #1, on 06/23/15 at 3:00 PM, revealed she was nervous during the observed medication pass on 06/22/15 and she should not have crushed the Potassium CL ER with the other medications. She stated she knew the Potassium CL ER was not to be crushed. Interview with the Director of Nursing (DON), on 06/23/15 at 11:15 AM, revealed the Potassium ER should not have been crushed. She stated a liquid form of the medication could have been ordered instead of the capsule. She additionally stated crushing the extended release medication would cause the medication to be immediately released into the body instead of over a period of time.	F 281	The Director of Nursing and/or the Assistant Director of Nursing will submit a summary of the findings to the monthly Quality Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Dietary Manager, and Maintenance Director, monthly x 3 months for further review and recommendations until the issue is resolved. July 24, 2015 The Charge Nurse acquired the immunization history on June 24, 2015, for Resident #8. All residents of the facility have potential to be affected. The Director of Nursing checked all new admissions from the prior 30 days to determine if each resident received the pneumococcal immunization(s) unless medically contraindicated, refused, or already immunized with no additional findings. This review was completed on June 24, 2015. The Licensed Nurses were re-educated to the facility policy for Pneumococcal Vaccination by the Assistant Director of Nursing beginning on June 24, 2015 and ending on July 23, 2015. A post-test will be given by the Assistant Director of	07/24/15	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334			

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F 334	<p>Continued From page 4</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>	F 334	<p>Nursing by July 23, 2015 to validate understanding.</p> <p>The Director of Nursing and/or Assistant Director of Nursing will audit all new admissions daily x 2 weeks to determine that all new patients' pneumococcal vaccination history is obtained upon admission, then 3x per week x 2 weeks, then as determined by the monthly Quality Improvement Committee.</p> <p>The Director of Nursing and/or the Assistant Director of Nursing will submit a summary of findings monthly to the monthly Quality Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Services Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Dietary Manager, Maintenance Director, and Recreation Director, monthly x 6 months for further review and recommendations until the issue is resolved.</p> <p style="text-align: right;">July 24, 2015</p>	07/24/15	

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F 334	<p>Continued From page 5</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy, it was determined the facility failed to ensure the medical record included documentation to indicate a resident either received the pneumonia vaccine or did not due to medical contraindications or refusal for one (1) of twelve (12) sampled residents (Resident #8).</p> <p>The findings include:</p> <p>Review of the facility policy titled "Pneumococcal Vaccination", last revised 05/04/15, revealed it is</p>	F 334		

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F 334	<p>Continued From page 6</p> <p>the facility's policy upon admission, to obtain the patient's pneumococcal vaccination history, offer an initial pneumococcal vaccine to all residents who have never received the vaccine, offer a different, second pneumococcal vaccine, if appropriate, based on recommended schedule. If immunization refused, document patient's or decision maker's reason for refusal of immunization, education, and counseling given regarding the benefit of immunization.</p> <p>Record review revealed the facility admitted Resident #8 on 06/19/15 with diagnosis to include Senile Dementia, Chronic Airway Obstruction, Anxiety, Depressive Disorder, Chronic Ischemic Heart Disease, and Adult Failure to Thrive.</p> <p>Review of Resident #8's Pneumococcal Immunization Informed Consent, dated 06/19/15, revealed the resident's daughter gave consent for the resident to receive the Pneumococcal Vaccine; however, review of the Resident #8's Immunization Record, revealed there was no documentation or notation of whether or not Resident #8 received the pneumonia vaccine.</p> <p>Interview with the Admission/Marketing Director (AMD), on 06/23/15 at 3:55 PM, revealed the facility process is to offer residents the pneumonia vaccine, if resident refuses, assess history of immunization for pneumonia vaccine. Record if the resident have been immunized, the date the vaccine was received, and record the immunization history of all vaccines on the resident's immunization record.</p> <p>Interview with the Director of Nursing (DON), on 06/23/15 at 11:15 AM, revealed the facility process is to assess all residents immunization</p>	F 334			

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F 334	Continued From page 7 history upon admission. Further interview revealed all residents are offered the pneumonia vaccine on admission, if refused or contraindicated, all the information should be recorded on the immunization record and kept in the resident's medical record. She stated, "this is considered as a part of the admission process".	F 334	Upon discovery the cook immediately cleaned the reach in refrigerator and freezer door handles including surrounding areas and the drip pan under the stove. The unlabeled/undated food item was removed immediately from the reach in refrigerator and discarded.		
F 371 SS=E	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 facility policy and procedure it was determined the facility failed to ensure it stored, prepared and distributed food under sanitary conditions. Observation on 06/21/15 revealed a piece of grilled meat in the reach in refrigerator that was not labeled or dated. In addition, the refrigerator and freezer door handles and surrounding area had a build up of grey colored grime and the stove drip pan had a build up of burned food debris and a large amount of elbow macaroni pieces. Review of the Census and Condition, dated	F 371	Kitchen Aide #1 was reeducated by the Dietary Manager on June 21, 2015, regarding not placing personal lunch items in the center refrigerator. All residents who consume food from the kitchen have the potential to be affected. The Dietary Manager conducted an audit on June 22, 2015, to observe for staff personal lunch items in the reach in refrigerator or freezer, cleanliness of reach in refrigerator and freezer door handles including surrounding areas, drip pan under stove and for unlabeled/undated food in the reach in refrigerator with corrective action upon discovery. The Dietary Manager began re-educating the cooks and dietary aids on June 21, 2015, on the cleaning procedure for freezer and reach in refrigerators, ovens including drip pans and on the need to label and date food items placed in the reach in refrigerator. Re-education also included not placing personal lunch items in the refrigerator or freezer. The re-education was completed on July 6, 2015. Post-tests given by the Dietary Manager		

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F 371	<p>Continued From page 8</p> <p>08/23/15, revealed there were forty-seven (47) residents in the building and all residents received there meals from the kitchen.</p> <p>The findings include:</p> <p>Review of the facility Cleaning Procedure for weekly and monthly cleaning, not dated, revealed to "Scrub exterior of equipment using appropriate products of detergent, quaternary or delimer.</p> <p>Review of the undated facility Cleaning Procedure for ovens for monthly cleaning revealed detergent, grease cutter or oven cleaner was to be used with scrub pad, nylon bristled brush, metal scraper, spray bottle, gloves and clean cloths. The procedure did not detail cleaning of the drip pan located on the stove.</p> <p>Observation of the facility kitchen on 06/21/15 at 10:00 AM revealed:</p> <ol style="list-style-type: none"> 1. A piece of grilled meat wrapped in plastic wrap that did not have a date or label of contents on it. 2. The reach in freezer and refrigerators were observed with a build up of grey grime on the door handles and surrounding areas. 3. The drip pan in the oven was completely covered with old burned food debris and a large amount of elbow macaroni piled to one (1) side. <p>Interview with Kitchen Aide #1, on 06/21/15 at 10:00 AM, revealed she had arrived short on time for her shift and put the grilled meat that was for her lunch in the resident's refrigerator.</p> <p>Interview with the Dietary Manager, on 08/21/15</p>	F 371	<p>will be completed to validate understanding.</p> <p>The Cook, Dietary Manager, Administrator, and/or Registered Dietitian will audit the reach in refrigerator, freezer and oven daily for four weeks for cleanliness and to ensure that all food items are labeled and dated and there are no staff lunch items placed in the reach in refrigerator or freezer. The audit will then be conducted two times per week for four weeks then one time per week for four weeks. Corrective action will be provided upon discovery.</p> <p>The Dietary Manager will submit a summary of the findings to the monthly Quality Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Dietary Manager, and Maintenance Director, monthly x 3 months for further review and recommendations until the issue is resolved.</p> <p style="text-align: right;">July 24, 2015</p>	07/24/15	

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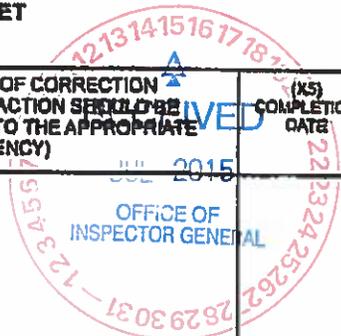
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F 371	Continued From page 9 at 10:30 AM, revealed everyone in the kitchen was responsible for ensuring the cleanliness and sanitation of the kitchen and the night shift was to check before leaving each day. Interview with the facility Registered Dietician, on 06/23/15 at 1:10 PM, revealed employees were to store personal food items in the break refrigerator and not the resident refrigerator. She stated the drip pan on the stove should be cleaned weekly and as needed by the night shift cook and the handles and surface areas on the refrigerators and freezers were to be cleaned every day.	F 371			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185167	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2015
NAME OF PROVIDER OR SUPPLIER HOPKINS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 460 SOUTH COLLEGE STREET WOODBURN, KY 42170	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1960 & 1978.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1978, with four (4) duct smoke detectors and one-hundred fourteen (114) heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1978 and upgraded in 1997.</p> <p>GENERATOR: Type II generator installed in 2000. Fuel source is Propane.</p> <p>A Recertification Life Safety Code Survey was conducted on 06/23/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has the capacity for fifty (50) beds with a census of forty-nine (49) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hopkins Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>Upon discovery the Maintenance Director contacted the alarm company. The Quality Assurance Manager from the alarm company updated the signals on Hopkins Center account to a higher priority to expedite notification. This updated was completed on July 6, 2015.</p> <p>All residents of the facility have the potential to be affected. A fire drill was held by the Maintenance Director on July 6, 2015, to test the response time with the fire system with no additional corrective action required.</p>	JUL 2015



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *W. Butler, Administrator* TITLE _____ (X6) DATE *07/14/15*

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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CENTERS FOR MEDICARE & MEDICAID SERVICES**

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NAME OF PROVIDER OR SUPPLIER HOPKINS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 460 SOUTH COLLEGE STREET WOODBURN, KY 42170	
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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	The administrator re-educated the Maintenance Director on June 29, 2015, regarding the need to ensure the fire system is maintained by the monitoring company according to the NFPA 72 (1999 Edition) standards. A post-test was completed to validate understanding.	
K 052 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire alarm system was maintained in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for fifty (50) beds and at the time of the survey, the census was forty-seven (47).	K 052	The Maintenance Director is monitoring the alarm response time weekly for 4 weeks then every other week times 4 weeks, then as determined by monthly Quality Improvement Committee with corrective action upon discovery. The Maintenance Director will submit a summary of the findings to the monthly Quality Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Dietary Manager, and Maintenance Director, for further review and recommendations until the issue is resolved. July 24, 2015	07/24/15

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NAME OF PROVIDER OR SUPPLIER HOPKINS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 480 SOUTH COLLEGE STREET WOODBURN, KY 42170	
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K 052	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observation, on 06/23/15 at 9:58 AM, with the Maintenance Supervisor revealed a test of the fire alarm automatic dialer panel sent a trouble signal to the monitoring company; however, the monitoring company failed to communicate immediately with persons designated by the subscriber within four (4) minutes. The monitoring company called the facility at 10:10 AM.</p> <p>Interview, on 06/23/15 at 9:59 AM, with the Maintenance Supervisor revealed he was not aware of the requirements for the monitoring company to contact the facility in a timely manner.</p> <p>Interview, on 06/25/15 at 10:00 AM, with the Sprinkler Contractor by phone revealed the monitoring company was not aware they must communicate immediately with persons designated by the subscriber. Further interview revealed the monitoring company was referencing the 2010 edition of NFPA 72 instead of the 1999 edition of NFPA 72.</p> <p>The census of forty-seven (47) was verified by the Administrator on 06/23/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 06/23/15</p> <p>Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.</p>	K 052		

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NAME OF PROVIDER OR SUPPLIER HOPKINS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 460 SOUTH COLLEGE STREET WOODBURN, KY 42170		
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K 052	<p>Continued From page 3 Reference: NFPA 72 (1999 edition)</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.</p> <p>5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p>	K 052		