

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

PRINTED: 05/24/2013
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 05/10/2013
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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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F 000	INITIAL COMMENTS A recertification survey was conducted on 05/08/13 through 05/10/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E".	F 000	"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 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."	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to promote care and services that maintains or enhances the dignity of one (1) resident (#9), in the selected sample of sixteen (16) residents, and one resident (#14), not in the selected sample. Staff toileted Resident # 9 and left the bathroom door open with Resident #9 in view of his/her roommate. In addition, staff failed to close both window blinds, pull the privacy curtains and keep Resident #14 covered while providing care. Findings include: A review of the facility's policy, titled "Privacy and Confidentiality" with no date, revealed a resident has the right to privacy in receiving personal and medical care and treatments, staff must knock on	F 241	F 241 Resident # 9 had her bathroom door closed by the certified nursing assistant while providing care on 5/8/13. Resident #14's dignity and respect was maintained by CNA #3. The privacy curtain was pulled securely around resident #14, the two window blinds pulled down and the blanket was placed on the resident to provide privacy and dignity by CNA #3 on 5/8/13. Nurse aide #2 and #3 were re-educated by the Staff Development Coordinator on 5/8/13 on providing care that enhances each resident's dignity, respect and privacy.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Dopey TITLE: Administrator (X6) DATE: 6/3/13

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

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F 241	<p>Continued From page 1</p> <p>the door before entering a resident's room. Doors must be closed during care and treatments, and staff must pull the privacy curtain and keep the resident covered as much as possible, to ensure the resident has complete privacy. If a resident must undress, they should not remain undressed any longer than necessary.</p> <p>1. A record review revealed Resident #14 was admitted to the facility on 02/16/11 with diagnoses to include Contractures of Hand Joints, Hypertension, Atrial Fibrillation, Dementia with behavioral disturbances, Osteoarthritis, and Depressive Disorder.</p> <p>A review of Resident #14's annual Minimum Data Set (MDS) assessment, dated 01/26/13, revealed the facility assessed Resident #14's cognition as severely impaired and totally dependent on staff for dressing and personal hygiene.</p> <p>An observation, on 05/08/13 at 10:00 AM, revealed Resident #14 was lying in the bed being dressed by Certified Nursing Aide (CNA) #3. The privacy curtains were not pulled around the bed to provide privacy and the curtain to the right of the resident's bed was tucked behind a chair. Both window blinds on each side of the residents room were open midway and not fully closed. When the surveyor entered the room, the CNA attempted to cover the resident with a white sheet. The location of the residents bed is at the entrance of the doorway.</p> <p>An interview with CNA #3 on 05/10/13 at 3:00 PM, revealed she should have pulled the curtains, closed the blinds and kept the resident covered.</p>	F 241	<p>Current Residents who required assist with their activities of daily living according to the MDS were chosen randomly by the Director of Nursing and Assistant Director of Nursing and observed during their routine care to ensure their privacy and dignity were maintained by the staff on 5/8/13.No other residents were affected.</p> <p>Licensed Nurses and Certified Nursing Assistants were re-educated by the Staff Development Coordinator on how to provide and maintain a resident's privacy, respect and dignity during care on 5/8/13.</p> <p>The Director of Nursing, and/or Assistant Director of Nursing, along with the Charge Nurse will observe five residents receiving assist with activities of daily living two times weekly for 4 weeks then weekly for a month and then monthly for one month to ensure privacy and dignity have been provided. The Director of Nursing will port findings to the Performance Improvement Committee monthly for three months for further recommendations.</p> <p>Completion Date:5/31/2013</p>	

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F 241	<p>Continued From page 2</p> <p>Interviews with CNAs #1, #6, and #8, on 05/10/13 at 11:00 AM, 11:30 AM, and 2:55 PM revealed staff should respect the resident's dignity by pulling the privacy curtains around the resident, closing the blinds and providing a sheet to keep the resident covered as much as possible while providing care.</p> <p>Interviews with Licensed Practical Nurse (LPN) #3, and LPN #1, on 05/10/13 at 2:30 PM and 2:35 PM, revealed staff should provide by making sure the privacy curtains are pulled around the resident and the window blinds were closed. In addition, staff should use a sheet or blanket to cover the resident as much as possible while providing care.</p> <p>An interview with the Director of Nursing (DON), on 05/10/13 at 4:30 PM, revealed she expected staff to close the door, pull the privacy curtain and close the blinds when providing care to a resident.</p> <p>2. A record review revealed Resident #9 was admitted to the facility on 12/18/11 with diagnoses to include Cognitive Defects due to Cerebrovascular Disease, Hypoglycemia, Diverticulitis, Difficulty in Walking, Senile Dementia, lack of coordination, muscle weakness and other malaise and fatigue.</p> <p>A review of the annual MDS assessment, dated 10/24/13, revealed the facility assessed Resident #9's cognition as severely impaired and the resident was totally dependent on one staff for toilet use.</p> <p>An observation, on 05/08/13 at 4:00 PM, revealed</p>	F 241			

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F 241	Continued From page 3 Resident #9 was sitting on the toilet in the bathroom with the bathroom door open. The resident was in clear view of his/her roommate who was lying in the bed across from the bathroom. An interview with CNA #2, on 05/08/13 at 4:00 PM, revealed the curtain should be closed, and the door should be shut to provide Resident #9 privacy. Interview with CNA #1, on 05/09/13 at 10:30 AM, revealed the bathroom door should be closed if another resident is in the room and privacy should be provided so that the resident is not exposed to anyone.	F 241		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility to provide services that met professional standards of quality for five (5) residents (#3, #4, #8, #9, and #11), in the selected sample of thirteen (13) residents, and one resident (#15), not in the selected sample. The facility failed to ensure the Comprehensive Care Plans were followed related to ensuring the	F 282	F 282 Alarms for residents #3, #4, #9 and #15 had the batteries replaced by the Licensed Nurse on 5/9/13. The alarms for residents # 8 and #11 were replaced by the Licensed Nurse on 5/10/2013. The air mattress setting for resident # 4 was reset by the Staff Development Coordinator and the Maintenance Director on 5/10/2013. Current residents who require alarms or an air mattress were reviewed on 5/24/2013, along with the residents' care plans, by the Assistant Director of Nursing to ensure the care plan/care card reflected the current alarm system and that the correct mattress setting was in place and correct on the care plan/care card. The Assistant Director of Nursing also audited the Treatment Administration records (TAR's) to ensure that the alarms were checked	

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F 282	<p>Continued From page 4</p> <p>alarms initiated were functioning for Resident #3, #4, #9 and #15, failed to ensure alarms were in place for Resident #8 and #11 and an air mattress was set at the appropriate mode for Resident #4.</p> <p>Findings include:</p> <p>A review of the facility's "Falls Management Program" policy, dated 01/2008, revealed once the care plan was developed, the team that would implement it has been identified, everyone involved should make sure the plan is carried out on a routine basis. Nursing assistants play a key role in implementing the plan, since they spend so much time with the residents each day. Licensed nurses need to be sure to communicate the components of the care plan to the nursing assistants. In addition to implementing many of the interventions, it's also important for nursing assistants to report successes and difficulties of the plan to the licensed nurse.</p> <p>1. A record review revealed Resident #4 was admitted to the facility on 04/25/11 with diagnoses to include Cerebral Vascular Accident, Depression, Type II Diabetes, Muscle Weakness, Chronic Ischemic Heart Disease, and Hypertension.</p> <p>A review of the quarterly MDS assessment, dated 03/19/13, revealed the facility assessed Resident #4's cognition as severely impaired and the resident was totally dependent on two staff for transfers and bed mobility. The resident had no history of falls. A review of the "Resident Fall Evaluation," dated 3/19/13, revealed the facility assessed the resident to have fall risk factors</p>	F 282	<p>every shift by the nurse for placement and functionality along with the proper setting for the air mattresses on 5/10/13. The Assistant Director of Nursing also checked the TAR's to ensure staff were documenting that batteries for the alarms were being replaced the 15th of every month on 5/24/2013.</p> <p>The Staff Development Coordinator re-educated the Licensed Nurses and Certified Nursing Assistants on following resident care plans and checking for proper placement and functionality of the alarms along with proper settings on air mattresses on 5/24/2013.</p> <p>Five residents with alarms or air mattresses will be checked by the Director of Nursing and or the Assistant Director of Nursing two times a week for a month, then five per week for one month then five per month for one month to ensure care is being provided in accordance with each residents written plan of care. The Director of Nursing will report findings monthly for three months to the Performance Improvement Committee for further recommendations.</p> <p style="text-align: right;">Completion Date 5/31/2013</p>	

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F 282	<p>Continued From page 5</p> <p>related to being totally dependent on two staff for transfers and bed mobility, the resident was on new medication and the resident's cognition was confused.</p> <p>A review of the Comprehensive Care Plan for Falls, dated 05/08/13; and the May 2013 Nursing Assistant Care Card, revealed Resident #4 should have a sensor pad alarm to the bed.</p> <p>Observations, on 05/08/13 at 10:35 AM, 2:40 PM, and 3:30 PM and on 05/09/13 at 10:25 AM and 12:15 PM, revealed Resident #4 was lying in his/her bed with the alarm on the bed but the sensor alarm was not flashing. Observation on 05/09/13 at 2:35 PM with Certified Nursing Aide (CNA) #1 revealed there was no battery in the sensor alarm device on Resident #4's bed.</p> <p>An interview with CNA #1, on 05/09/13 at 2:35 PM, revealed staff was supposed to check the alarm box when the resident was on the bed, so there was pressure to the bed.</p> <p>An interview with LPN #2, on 05/09/13 at 3:00 PM, revealed she tried to look at the alarms every day, but she don't always get to them. The LPN revealed if the alarm was not flashing, then there is a problem.</p> <p>An interview with LPN #1 on 05/09/13 at 3:05 PM, revealed she monitors chair and bed alarms by visually checking them to make sure the switch is turned on. The LPN stated she tries to look at the alarms at least twice on her shift.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 05/09/13 at 2:40 PM, revealed the</p>	F 282		

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F 282	<p>Continued From page 6</p> <p>LPN had just told her there was no battery in Resident #4's alarm box. She stated the alarm was listed on the Treatment Administration Record (TAR) for licensed staff to check every shift and ensure the alarm was in place but it did not address ensuring the alarm was functioning.</p> <p>Further review of the Comprehensive Care Plan revealed a problem for potential for skin breakdown, dated 05/08/13, with an intervention for Resident #4 to have the air mattress mode set to pulsate.</p> <p>Observations on 05/08/13 at 2:40 PM, and on 05/09/13 at 10:25 PM, 12:15 PM, and 2:35 PM revealed Resident #4's low air loss air mattress mode setting was on Therapy mode.</p> <p>An interview with LPN #2, on 05/10/13 at 9:20 AM, revealed she's not sure how the setting on the low air loss mattress mode would be on therapy mode, as she actually goes in the room and visually looks at the settings to make sure they are on the proper settings. The LPN stated she checked the settings every morning around 6:30 AM-6:45 AM.</p> <p>An interview with ADON on 05/10/13 at 10:05 AM, revealed she expected the nurses to check the TAR and physicians order's to see what setting the air mattress mode is to be set at, and to visualize it once a shift as expected, then to check it off on the TAR, if they notice a problem they should notify maintenance immediately. I can't think of a reason why the mode setting would be on the wrong setting.</p> <p>2. A record review revealed Resident #8 was</p>	F 282			

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F 282	<p>Continued From page 7</p> <p>admitted to the facility on 10/18/12 with diagnoses to include Chronic Ischemic Heart Disease, Persistent Mental Disorder, Altered Mental Status, Congestive Heart Failure, Difficulty Walking and Muscle Weakness.</p> <p>A review of the "Resident Fall Evaluation," dated 04/19/13, revealed the facility assessed the resident to have fall risk factors related to the resident was totally dependent on two staff for transfers and bed mobility, resident's behavioral issues and resident's cognition was confused.</p> <p>A review of a quarterly MDS assessment, dated 05/20/13, revealed the facility assessed Resident's #8's cognition as severely impaired and the resident was totally dependent on two staff for transfers and bed mobility. The resident had no fall history.</p> <p>A review of the Comprehensive Care Plan, printed 05/02/13, revealed a chair alarm was initiated on 11/01/12. A review of the Nursing Assistant Care Card, dated May 2013, revealed Resident #8 should have a chair alarm.</p> <p>Observations on 05/08/13 at 10:20 AM, 12:45 PM, and 2:45 PM and on 05/09/13 at 10:30 AM, 12:25 PM, 2:10 PM and 3:50 PM revealed there was no sensor alarm attached to the resident's wheel chair.</p> <p>An interview with CNA #8, on 05/10/13 at 10:10 AM, revealed Resident #8 was care planned for a sensor alarm to his/her wheelchair. The LPN stated the alarm on the wheelchair is a sensor alarm and the resident should always have it on whenever he/she is up in the wheelchair.</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>An interview with the ADON, on 05/10/13 at 10:15 AM, revealed Resident #8 is care planned for a chair alarm for his/her wheel chair.</p> <p>An interview with the DON, on 05/10/13 at 4:30 PM, revealed she expected the staff to follow the resident's comprehensive care plan and resident's care cards.</p> <p>3. A record review revealed Resident #11 was admitted to the facility with diagnoses to include Fracture of Humerus, Chronic Ischemic Heart Disease, Osteoporosis and Dementia. Resident #11 had a fall resulting in a fractured Humerus at home, was hospitalized and admitted to the facility for therapy.</p> <p>A review of the admission Resident Fall Evaluation and admission Minimum Data Set (MDS) assessment, dated 05/03/13, revealed the facility assessed Resident #11 as high risk for falls.</p> <p>A review of the Comprehensive Care Plan for risk for falls and the Nursing Assistant Care Card, dated 05/2013, revealed interventions for a sensor alarm to the chair.</p> <p>Observations on 05/10/13 at 9:42 AM and 10:50 AM revealed Resident #11 was in the dining area sitting in a wheelchair and had his/her right arm in a sling. There was no sensor alarm in place on the wheelchair.</p> <p>Further observation, on 05/10/13 at 11:50 AM, revealed Resident #11 was in the wheelchair in the front lobby area with peers and there was no</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>alarm visible to the resident's wheelchair. Interview and observation with the Administrator at this time, verified there was no sensor alarm in place on the resident's wheelchair. The Assistant Director of Nursing (ADON) obtained a new (still in the package) alarm and placed it to Resident #11's wheelchair at 11:55 AM.</p> <p>Interview with the Administrator and the Assistant Director of Nursing (ADON), on 05/10/13 at 11:55 AM, revealed they were unaware Resident #11 was to have a sensor alarm to the wheelchair as per the care plan</p> <p>An interview conducted with Certified Nurse Aide (CNA) #1, on 05/10/13 at 12:05 PM, revealed she was unaware Resident #11 was to have a sensor alarm to the chair and was unaware the alarm was listed on the Nursing Assistant Care Card.</p> <p>An interview with the Director of Nursing (DON), on 05/10/13 at 12:00 PM and 4:15 PM, revealed she was not aware Resident #11 had been assessed as requiring an alarm. She stated there would be interventions on the resident care plan. The DON stated the nurse was ultimately responsible for ensuring a sensor alarm was in place and functioning.</p> <p>4. A record review revealed Resident #3 was admitted to the facility on 01/26/12 with diagnoses to include malaise and fatigue, Atrial Fibrillation, shortness of breath, difficulty in walking, Cardiac Pacemaker in Situ, personal history of fall, Syncope and collapse, and personal history of a Traumatic Fracture.</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>A review of the Falls Risk Care Plan revealed an intervention for a sensor pad alarm to chair was initiated on shows interventions initiated on 09/01/12.</p> <p>A review of the quarterly MDS assessment, dated 03/18/13, revealed the facility assessed Resident #3's cognition as severely impaired and the resident required extensive assistance of staff for transfers.</p> <p>Observation on 05/09/13 at 8:37 AM, 9:32 AM, 10:25 AM, and 10:40 AM revealed Resident #3's alarm box to chair sensor was not flashing.</p> <p>Interview with CNA #1, on 05/09/13 at 10:40 AM, revealed the chair sensor light was not on and when checked the alarm was not turned on.</p> <p>5. A record review revealed Resident #9 was admitted to the facility on 12/18/11 with diagnoses to include Altered Mental Status, Malaise and Fatigue, Muscle Weakness, Lack of Coordination, Difficulty in Walking, Anemia, and Abnormality of Gait.</p> <p>A review of the annual MDS assessment, dated 10/24/12, revealed the facility assessed Resident #9's cognition as severely impaired and the resident was dependent on staff for transfers and required extensive assistance for ambulation.</p> <p>A review of the Fall Risk Comprehensive Care Plan and Nursing Assistant Care Card revealed a sensor alarm to chair was initiated on 02/06/13.</p> <p>A review of Fall Investigation, dated 05/08/13, revealed Resident #9 fell from the wheelchair</p>	F 282			

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F 282	Continued From page 11 going to the bathroom and was found with the alarm not sounding. Interviews with CNA #1 and CNA #2, on 05/10/13 at 11:30 AM, revealed Resident #9 had fallen in the bathroom on 05/08/13 and the alarm to the wheelchair was not sounding. CNA #2 further stated the wheelchair alarm battery was dead or defective because it was not sounding. Interview with LPN #3, on 05/10/13 at 3:05 PM, revealed the alarm did not sound and she had to change out the battery to the alarm because it was not functioning. 6. A record review revealed Resident #15 was admitted to the facility on 05/01/12 with diagnoses to include Abnormality of Gait, personal history of fall, Hypothyroidism, and Essential Hypertension. A review of the Fall Risk Comprehensive Care Plan and the Nursing Assistant Care Card revealed a sensor alarm to Resident #15's bed was initiated on 05/04/12. Observation of Resident #15 with CNA #1, on 05/09/13 at 10:36 AM, revealed the bed alarm to the resident's bed was not lit up and CNA #1 had to press the sensor pad three times before the alarm went off. Interview with LPN #1, on 05/10/13 at 9:17 AM, revealed the nurse on the floor was ultimately responsible to make sure that everyone is compliant with checking alarms.	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	<p>Continued From page 12</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for five (#5) residents (#3, #4, #8 #9, and #11) in the selected sample of thirteen (13) residents and one resident (#15), not in the selected sample. The facility failed to have an effective system in place to ensure Residents' #3, #4, #9 and #15 alarms were functioning appropriately and Residents' #8 and #11 alarms were in place.</p> <p>Findings include:</p> <p>A review of the "Fall Management Program", dated 01/2008, revealed the objective of the facility was to implement interventions to prevent falls and to ensure a safe environment and reduce the likelihood of injury from a fall.</p> <p>1. A record review revealed Resident #11 was admitted to the facility with diagnoses to include Fracture of Humerus, Chronic Ischemic Heart Disease, Osteoporosis and Dementia. Resident</p>	F 323	<p>F323</p> <p>The Licensed Nurse re-applied functioning alarms to residents # 3, #4, #8, #9, #11 and #15 on 5/10/13.</p> <p>Current residents with alarms and air mattresses were checked for settings, placement and functionality by the Staff Development Coordinator on 5/9/2013. Any discrepancies were immediately corrected at that time.</p> <p>The Staff Development Coordinator re-educated the licensed nurses and certified nursing assistants on 5/24/2013, on adequate supervision and assistive devices to prevent accidents to include checking placement and function..</p> <p>Five residents with alarms will be checked by the Assistant Director of Nursing two times a week for a month, then five per week for one month then five per month for one month to ensure placement and function to prevent accidents. The Assistant Director of Nursing will report findings to the Performance Improvement Committee for three months for further recommendations.</p> <p>Completion Date: 5/31/2013</p>		

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F 323	<p>Continued From page 13</p> <p>#11 had a fall resulting in a fractured Humerus at home, was hospitalized and admitted to the facility for therapy.</p> <p>A review of the admission Resident Fall Evaluation and admission Minimum Data Set (MDS) assessment, dated 05/03/13, revealed the facility assessed Resident #11 as a high risk for falls.</p> <p>A review of Resident #11's Physician's Orders, Comprehensive Care Plan for risk for falls and the Nursing Assistant Care Card, dated 05/2013, revealed the resident should have a sensor alarm to the wheelchair.</p> <p>Observations on 05/10/13 at 9:42 AM and 10:50 AM revealed Resident #11 was in the dining area sitting in a wheelchair and had his/her right arm in a sling. There was no sensor alarm in place on the wheelchair. Further observation on 05/10/13 at 11:50 AM revealed Resident #11 was in the wheelchair in the front lobby area with peers and there was no alarm visible to the resident's wheelchair. Interview and observation with the Administrator at this time, verified there was no sensor alarm in place on the resident's wheelchair.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 05/10/13 at 12:05 PM, revealed she was unaware Resident #11 was to have a sensor alarm to the chair and was unaware the alarm was listed on the Nursing Assistant Care Card.</p> <p>An interview with the Director of Nursing (DON), on 05/10/13 at 12:00 PM and 4:15 PM, revealed she was not aware Resident #11 had been</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>assessed as requiring an alarm. The DON revealed the placement and function of the sensor alarms was documented on the Treatment Administration Record (TAR) by the licensed nurse. Additionally, the DON stated the nurse was ultimately responsible for ensuring a sensor alarm was in place and functioning.</p> <p>2. A record review revealed Resident #4 was admitted to the facility on 04/25/11 with diagnoses to include Cerebral Vascular Accident, Depression, Type II Diabetes, Muscle Weakness, Chronic Ischemic Heart Disease, and Hypertension.</p> <p>A review of the quarterly MDS assessment, dated 03/19/13, revealed the facility assessed Resident #4's cognition as severely impaired and the resident was totally dependent on two staff for transfers and bed mobility. The resident had no history of falls. A review of the "Resident Fall Evaluation," dated 3/19/13, revealed the facility assessed the resident to have fall risk factors related to being totally dependent on two staff for transfers and bed mobility, the resident was on new medication and the resident's cognition was confused.</p> <p>A review of the physician's orders, dated 05/2013, revealed Resident #4 should have an alarm attached to the lap tray to alert staff of repositioning.</p> <p>A review of the Device Evaluation Summary Risk Assessment for sensor alarm to lap tray, dated 03/27/13, revealed a consent was obtained from the family and a physician's order was obtained.</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>The purpose of the sensor alarm to the lap tray was to alert the staff if the resident was pushing the lap tray off.</p> <p>A review of Resident #4's May 2013 Treatment Administration Record (TAR) revealed the alarm was attached to the lap tray and the boxes were initialed for day, evening and night which indicated the alarm was in place.</p> <p>Observation on 05/09/13 at 8:40 AM revealed Resident #4 was sitting in the front lobby with the lap tray unattached, the resident was partially leaning toward the floor, and the lap tray alarm was not sounding.</p> <p>An interview with CNA #7, on 05/09/13 at 3:30 PM, revealed Resident #4's lap tray alarm is like a pull tab alarm, when Resident #4 pushes on his/her tray too far the alarm will sound, so we can tell he/she has pushed the tray away. The CNA stated she had heard the alarm go off at times but could provide no explanation as to why the alarm did not sound.</p> <p>An interview with LPN #1, on 05/09/13 at 3:05 PM, revealed she was not aware an alarm needed to be attached to Resident #4's lap tray.</p> <p>Further review revealed a physician's order, dated 05/2013; a Comprehensive Care Plan for Falls, dated 05/08/13; and the May 2013 Nursing Assistant Care Card revealed Resident #4 should have a sensor pad alarm to the bed.</p> <p>A review of Resident #4's May 2013 TAR revealed a sensor pad alarm to bed and the boxes were initialed for day, evening and night</p>	F 323			

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F 323	<p>Continued From page 16 indicating the sensor pad alarm was in place.</p> <p>Observations, on 05/08/13 at 10:35 AM, 2:40 PM, and 3:30 PM and on 05/09/13 at 10:25 AM and 12:15 PM, revealed Resident #4 was lying in his/her bed with the alarm on the bed but the sensor alarm was not flashing. Observation on 05/09/13 at 2:35 PM with Certified Nursing Aide (CNA) #1 revealed there was no battery in the sensor alarm device on Resident #4's bed.</p> <p>An interview with CNA #1, on 05/09/13 at 2:35 PM, revealed the device takes a nine (9) volt battery and it would blink green if it was properly working. The CNA stated she was not sure why there was no battery in the alarm box. The CNA revealed staff was supposed to check the alarm box when the resident was on the bed, so there was pressure to the bed.</p> <p>An interview with LPN #2, on 05/09/13 at 3:00 PM, revealed she noticed the sensor alarm wasn't working because it wasn't flashing, so she went to get a screw driver, so she could replace it with a new battery. The LPN stated she tried to look at the alarms every day, but she don't always get to them. The LPN revealed if the alarm was not flashing, then there is a problem. The LPN stated the alarm was on the TAR, but it only addressed ensuring the alarm was in place. The TAR did not address checking the alarm to ensure it was functioning.</p> <p>An interview with LPN #1 on 05/09/13 at 3:05 PM, revealed she monitored chair and bed alarms by visually checking them to make sure the switch is turned on. The LPN stated she tries to look at the alarms at least twice on her shift. The LPN</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>revealed the TAR only addressed ensuring an alarm was in place, it did not address ensuring it was functioning. The LPN stated the battery was changed when the battery indicator revealed the battery was weak</p> <p>3. A record review revealed Resident #8 was admitted to the facility on 10/18/12 with diagnoses to include Chronic Ischemic Heart Disease, Persistent Mental Disorder, Altered Mental Status, Congestive Heart Failure, Difficulty Walking and Muscle Weakness.</p> <p>A review of the "Resident Fall Evaluation," dated 04/19/13, revealed the facility assessed the resident to have fall risk factors related to the resident was totally dependent on two staff for transfers and bed mobility, resident's behavioral issues and resident's cognition was confused.</p> <p>A review of a quarterly MDS assessment, dated 05/20/13, revealed the facility assessed Resident's #8's cognition as severely impaired and the resident was totally dependent on two staff for transfers and bed mobility. The resident had no fall history.</p> <p>A review of physicians orders, dated 05/2013, revealed there should be a sensor pad alarm to Resident #8's wheel chair when up.</p> <p>A review of the Comprehensive Care Plan, printed 05/02/13, revealed a chair alarm was initiated on 11/01/12. A review of the Nursing Assistant Care Card, dated May 2013, revealed Resident #8 should have a chair alarm.</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>Observations on 05/08/13 at 10:20 AM, 12:45 PM, and 2:45 PM and on 05/09/13 at 10:30 AM, 12:25 PM, 2:10 PM and 3:50 PM revealed there was no sensor alarm attached to the resident's wheel chair.</p> <p>An interview with CNA #8, on 05/10/13 at 10:10 AM, revealed Resident #8 has a sensor alarm to his/her wheelchair and it flashes when it's working. The LPN stated the alarm on the wheelchair is a sensor alarm and the resident should always have it on whenever he/she is up in the wheelchair.</p> <p>An interview with the ADON, on 05/10/13 at 10:15 AM, revealed Resident #8 is care planned for a chair alarm for his/her wheel chair. The current system we have in place is the alarms are placed on the TAR, the nurses read the TAR, and the nurses then visualize the alarms to make sure they are in place.</p> <p>4. A record review revealed Resident #3 was admitted to the facility on 01/26/12 with diagnoses to include malaise and fatigue, Atrial Fibrillation, shortness of breath, difficulty in walking, Cardiac Pacemaker in Situ, personal history of fall, Syncope and collapse, and personal history of a Traumatic Fracture.</p> <p>A review of the Falls Risk Care Plan revealed an intervention for a sensor pad alarm to chair was initiated on shows interventions initiated on 09/01/12.</p> <p>A review of the quarterly MDS assessment, dated 03/18/13, revealed the facility assessed Resident #3's cognition as severely impaired and the</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>resident required extensive assistance of staff for transfers.</p> <p>Observation on 05/09/13 at 8:37 AM, 9:32 AM, 10:25 AM, and 10:40 AM revealed Resident #3's alarm box to chair sensor was not flashing.</p> <p>Interview with CNA #1, on 05/09/13 at 10:40 AM, revealed the chair sensor light was not on and when checked the alarm was not turned on.</p> <p>5. A record review revealed Resident #9 was admitted to the facility on 12/18/11 with diagnoses to include Altered Mental Status, Malaise and Fatigue, Muscle Weakness, Lack of Coordination, Difficulty in Walking, Anemia, and Abnormality of Gait.</p> <p>A review of the annual MDS assessment, dated 10/24/12, revealed the facility assessed Resident #9's cognition as severely impaired and the resident was dependent on staff for transfers and required extensive assistance for ambulation.</p> <p>A review of the Fall Risk Comprehensive Care Plan and Nursing Assistant Care Card revealed a sensor alarm to chair was initiated on 02/06/13.</p> <p>A review of Fall Investigation, dated 05/08/13, revealed Resident #9 fell from the wheelchair going to the bathroom and was found with the alarm not sounding.</p> <p>Interviews with CNA #1 and CNA #2, on 05/10/13 at 11:30 AM, revealed Resident #9 had fallen in the bathroom on 05/08/13 and the alarm to the wheelchair was not sounding. CNA #2 further stated the wheelchair alarm battery was dead or</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>defective because it was not sounding.</p> <p>Interview with LPN #3, on 05/10/13 at 3:05 PM, revealed the alarm did not sound and she had to change out the battery to the alarm because it was not functioning.</p> <p>6. A record review revealed Resident #15 was admitted to the facility on 05/01/12 with diagnoses to include Abnormality of Gait, personal history of fall, Hypothyroidism, and Essential Hypertension.</p> <p>A review of the Fall Risk Comprehensive Care Plan and the Nursing Assistant Care Card revealed a sensor alarm to Resident #15's bed was initiated on 05/04/12.</p> <p>A review of the Physician's Orders for 05/2013 revealed Resident #15 should have a sensor pad alarm to bed and it should be checked for functionality every shift.</p> <p>Observation of Resident #15 with CNA #1, on 05/09/13 at 10:36 AM, revealed the bed alarm to the resident's bed was not lit up and CNA #1 had to press the sensor pad three times before the alarm went off.</p> <p>Interview with LPN #1, on 05/10/13 at 9:17 AM, revealed the nurse on the floor was ultimately responsible to make sure that everyone is compliant with checking alarms.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 05/09/13 at 2:40 PM, revealed alarms was listed on the Treatment Administration Record (TAR) for licensed staff to check every shift and ensure the alarm was in</p>	F 323			

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F 323	Continued From page 21 place but it did not address ensuring the alarm was functioning. An interview with the DON, on 05/10/13 at 4:30 PM, revealed all alarms should be in working order. The DON revealed the placement and function of the sensor alarms was documented on the Treatment Administration Record (TAR) by the licensed nurse. The DON revealed the nurse was ultimately responsible for ensuring a sensor alarm was in place and functioning. She expected the nurses and the CMTs to check for placement of the alarms and to make sure the alarms were in proper working order.	F 323			
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to be administered in a manner that enabled it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental and physical well-being of each resident. During a Life Safety Code (LSC) survey, conducted 05/09/13, there were repeat deficiencies that were cited on the previous annual survey conducted on 02/16/12. (Refer to K50)	F 490	F490 Facility fire drills will be conducted randomly per regulations by the Maintenance Director and/or administration. A Fire drill was conducted by the Maintenance Director at 1715 on 5/29/13. The fire drill process was reviewed by the Maintenance Director and the schedule updated to reflect random fire drills to be held at unexpected times under varying conditions according to K 050 on 5/29/2013. The Maintenance Director was re-educated by the Regional Property Manager on 5/10/13 to conduct fire drills at unexpected times under varying conditions according to K 050. The Department Head team were re-educated by the Regional Vice President on administering the		

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F 490	Continued From page 22 Interview with the Administrator on 05/10/13 revealed she thought the fire drills that were conducted had been random and knew the plan of correction had been met. The audits that were conducted all had cleared.	F 490			

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F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to be administered in a manner that enabled it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental and physical well-being of each resident. During a Life Safety Code (LSC) survey, conducted 05/09/13, there were repeat deficiencies that were cited on the previous annual survey conducted on 02/16/12. (Refer to K50)	F 490	F490 Facility fire drills will be conducted randomly per regulations by the Maintenance Director and/or administration. A Fire drill was conducted by the Maintenance Director at 1715 on 5/29/13. The fire drill process was reviewed by the Maintenance Director and the schedule updated to reflect random fire drills to be held at unexpected times under varying conditions according to K 050 on 5/29/2013. The Maintenance Director was re-educated by the Regional Property Manager on 5/10/13 to conduct fire drills at unexpected times under varying conditions according to K 050. The Department Head team were re-educated by the Regional Vice President on administering the		

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F 490	Continued From page 22 Interview with the Administrator on 05/10/13 revealed she thought the fire drills that were conducted had been random and knew the plan of correction had been met. The audits that were conducted all had cleared.	F 490	facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident to include repeat deficiencies on 5/31/13. The Administrator will review the plan of correction quarterly for one year to include fire drills and report findings to the Performance Improvement Committee quarterly for further recommendations. Completion Date: 5/31/2013		

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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 V (111)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is liquid propane.</p> <p>A standard Life Safety Code survey was conducted on 05/09/13. Hopkins Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty (50) beds and the census was fifty (50) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</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>		

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

TITLE

(X6) DATE

Jessica Hope

Administrator

6/3/13

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

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K 000	Continued From page 1	K 000			
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for fifty (50) beds with a census</p>	K 018	<p>Approved door seals were installed on the following doors: 3, 11, 14, 19, and 21 on 5/12/13 by the Maintenance Director. The chain across the doorway between the kitchen and the dining area was immediately removed.</p> <p>The Maintenance Director audited all doors for impediments that would resist the passage of smoke and latch securely on 5/18/13. Any additional areas identified were also corrected.</p> <p>The Maintenance Director was re-educated by the Property Manager regarding doors resisting the passage of smoke and impediments to the closure of doors (no more than 1/8 inch gap) on 5/14/13.</p> <p>The Maintenance Director will audit ten doors each month for three months to ensure the doors have no more than a 1/8 inch gap. The Maintenance Director will report the results to the Performance Improvement Committee monthly for three months for further recommendations.</p> <p>Completion Date 06/12/13</p>		

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K 018	<p>Continued From page 2 of fifty (50) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/09/13 between 10:30 AM and 4:00 PM with the Maintenance Supervisor, revealed the corridor doors to room's #3, 11, 14, 19, and 21 had a gap greater than one half (1/2) inch between the door and the door stop on the jamb and would not resist the passage of smoke. Further observation revealed a chain across the doorway between the Kitchen and the Dining Area.</p> <p>Interview, on 05/10/13 between 10:30 AM and 4:00 PM with the Maintenance Supervisor, revealed he was not aware the doors had a gap too large. Further interview revealed he was not aware the chain was not permitted.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>18.3.6.3.1* Doors protecting corridor openings shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>18.3.6.3.2 Doors shall be provided with positive latching hardware. Roller latches shall be prohibited.</p>	K 018			

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K 018	<p>Continued From page 2 of fifty (50) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/09/13 between 10:30 AM and 4:00 PM with the Maintenance Supervisor, revealed the corridor doors to room's #3, 11, 14, 19, and 21 had a gap greater than one half (1/2) inch between the door and the door stop on the jamb and would not resist the passage of smoke. Further observation revealed a chain across the doorway between the Kitchen and the Dining Area.</p> <p>Interview, on 05/10/913 between 10:30 AM and 4:00 PM with the Maintenance Supervisor, revealed he was not aware the doors had a gap too large. Further interview revealed he was not aware the chain was not permitted.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>18.3.6.3.1* Doors protecting corridor openings shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>18.3.6.3.2 Doors shall be provided with positive latching hardware. Roller latches shall be prohibited.</p>	K 018			

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K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for fifty (50) beds with a census of fifty (50) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/09/13 at 2:37 PM with the Maintenance Supervisor, revealed the mechanical closet located next to the beauty shop did not have a ceiling which left the gas fired furnace open to the attic.</p> <p>Interview, on 05/09/13 at 2:37 PM, with the Maintenance Supervisor revealed the furnace</p>	K 029	<p>Maintenance director installed a ceiling in the mechanical closet located next to the beauty shop to create a barrier to resist the passage of smoke on 5/31/13.</p> <p>The Maintenance Director completed a facility inspection for hazardous storage areas on 5/09/13 and identified no other areas that required correction.</p> <p>The Maintenance Director was re-educated by the Property Manager on 5/14/13 related to the need of all hazardous areas being safeguarded by a fire barrier having a 1-hour fire resistance rating</p> <p>The Maintenance Director will inspect the facility hazardous storage areas for the integrity of the 1 hour fire rated construction on a monthly basis for three months. The Maintenance Director will report findings to the Performance Improvement Committee monthly for three months for further recommendations.</p>	

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K 029	Continued From page 6 was replaced the week before and he did not realize the installer had removed the ceiling Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be	K 029			

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K 029	Continued From page 7 permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for fifty (50) beds with a census of fifty (50) on the day of the survey. The findings include: Observation, on 05/09/13 between 10:30 AM and 4:00 PM, with the Maintenance Supervisor revealed the delayed egress doors located throughout the facility were equipped with delayed egress doors; however the signage did not have a contrasting background making the signage easily visible.	K 038	The Facility Maintenance Director added a temporary background immediately on 5/9/13 creating a contrasting background making the signage easily visible. Facility Maintenance director completed a facility door audit on 5/9/13 and all doors identified had a temporary background added. Permanent signs with contrast were installed on all doors 05/31/13. The Maintenance Director was re-educated by the Property Manager on 5/14/13 regarding proper signage. The Maintenance Director will inspect the facility delayed egress doors to validate each contains a contrasting background on the signage so that it's easily visible. Audits will be conducted at least monthly for 3 months. The Maintenance Director will report findings to the Performance Improvement Committee for three months Completion Date 06/12/13		

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K 038	<p>Continued From page 8</p> <p>Interview, on 05/09/13 between 10:30 AM and 4:00 PM, with the Maintenance Supervisor revealed he was not aware the delayed egress signage was required to be on a contrasting background.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power</p>	K 038			

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K 038	<p>Continued From page 9 controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO</p>	K 038		

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K 038	Continued From page 10 EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046		

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K 046	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation, and interview it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for fifty (50) beds with a census of fifty (50) on the day of the survey. The facility failed to test emergency battery lighting for 30 seconds monthly and 90 minutes annually.</p> <p>The findings include:</p> <p>Observation, on 05/09/13 at 12:05 AM, with the Maintenance Supervisor revealed the facility did not have documentation for monthly testing, or the annual testing of emergency battery lighting located in the facility.</p> <p>Interview, on 05/09/13 at 12:05 AM, with the Maintenance Supervisor revealed he was not aware documentation was to be kept on emergency battery light testing.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6</p>	K 046	<p>The Facility Maintenance Director tested and documented all emergency battery lighting for 30 seconds (monthly requirement) on 5/29/13.</p> <p>The Maintenance Director was re-educated by the Property Manager on 5/14/13 regarding testing and documentation requirements for emergency lighting.</p> <p>The Maintenance Director will document emergency lighting testing monthly. The Maintenance Director will report findings to the Performance Improvement Committee monthly for three months for further recommendations.</p> <p style="text-align: center;">Completion Date 06/12/13</p>		

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K 046	Continued From page 12 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050			

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K 050	Continued From page 13 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for fifty (50) beds with a census of fifty (50) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times on all shift. The findings include: Fire Drill review, on 05/09/13 at 11:30 AM, with the Maintenance Supervisor revealed the facility failed to conduct fire drills at unexpected times on all shift. The facility conducted fire drills quarterly on all shifts; however the times were within the same hours on all shifts. This is a repeat deficiency from a survey conducted in 2012. Interview, on 04/30/13 at 10:38 AM, with the Facility Management revealed he was not aware the fire drills were not being conducted as required. Further interview revealed he thought varied conditions was referring to the dates not the times. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied	K 050	The Facility Maintenance Director will conduct fire drills at unexpected times. A fire drill was held at 7:15 p.m. on 5/29/13 with more than 2 hours variance from the prior quarter. The Maintenance Director was re-educated by the Property Manager on 5/14/13 regarding conducting fire drills at unexpected times. The Administrator will review fire drills at least quarterly and review the times of the drills with the Performance Improvement Committee for six months for further recommendations. Completion Date 06/12/13	

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K 050	Continued From page 14 conditions on all shifts. Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050			
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056			

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K 056 SS=F	<p>Continued From page 15</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for fifty (50) beds with a census of fifty (50) on the day of the survey. The facility failed to ensure the facility had complete sprinkler coverage.</p> <p>The findings include:</p> <p>Observation, on 05/09/13 between 10:30 AM and 4:00 PM, Maintenance Supervisor revealed light fixtures installed within twelve (12 inches of a sprinkler head located in the Business Office, Office Managers Office, DON Office, Dietary Janitor Office, Middle Dining Room, Front Dining</p>	K 056	<p>The Facility Maintenance Director relocated light fixtures in the business office, Office Managers Office, DON Office, Dietary Janitor Office, Middle Dining Room, Front Dining Room and in rooms#20, 21, 18, 23, 17, 24, 16, 27, 5, 4, 2, 6, 7, 11, 8, and 10. A bid was obtained to move sprinkler heads for coverage for wardrobe type clothes located in rooms #4, 17, 18, 19, 20, and in the DON office.</p> <p>The Maintenance Director conducted a facility wide audit to identify light fixtures installed within twelve (12 inches of a sprinkler head). Any identified areas will have the light fixture relocated as needed. An agreement has been implemented with a vendor to add sprinkler heads in rooms that required additional sprinkler coverage; work will be completed as allowed by the vendor's schedule.</p> <p>The Maintenance Director was re-educated by the Property Manager on 5/14/13 regarding the maximum allowable distance of sprinkler heads and an obstruction per NFPA standards.</p> <p>The Maintenance Director will conduct monthly audits of sprinkler heads for three months. The Maintenance Director will report findings to the Performance Improvement Committee for three months for further recommendations.</p> <p>Completion Date 06/12/13</p>	

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K 056	<p>Continued From page 16</p> <p>Room, rooms #20, 21, 22, 18, 23, 17, 24, 16, 27, 5, 4, 2, 6, 7, 11, 8, and 10.</p> <p>Interview, on 05/09/13 between 10:30 AM and 4:00 PM, with the Maintenance Supervisor revealed he had just become aware of the sprinkler head requirement.</p> <p>Observation, on 05/09/13 between 10:30 AM and 4:00 PM, Maintenance Supervisor revealed inadequate sprinkler coverage for wardrobe type closets located in rooms# 4, 17, 18, 19, 20, and the DON Office.</p> <p>Interview, on 05/09/13 between 10:30 AM and 4:00 PM, with the Maintenance Supervisor revealed he was not aware the rooms had inadequate coverage.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position</p>	K 056		

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K 056	<p>Continued From page 17</p> <p>of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises</p> <p>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</p> <p>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>of Deflector Obstruction (in.)</th> </tr> </thead> <tbody> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>21/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>31/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>51/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>71/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>91/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>161/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </tbody> </table>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	21/2	1 ft 6 in. to less than 2 ft	31/2	2 ft to less than 2 ft 6 in.	51/2	2 ft 6 in. to less than 3 ft	71/2	3 ft to less than 3 ft 6 in.	91/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	161/2	5 ft and greater	18	K 056		
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K 056	Continued From page 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response	K 056			

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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 05/09/2013
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 056	Continued From page 19 sprinklers shall be permitted to be used. Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 056			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062			

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K 062	Continued From page 20 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for fifty (50) beds with a census of fifty (50) on the day of the survey. The facility failed to provide a sprinkler head wrench for the sprinkler heads. The findings Include: Observation on 05/09/13 at 3:23 PM, with the Maintenance Supervisor revealed the facility failed to provide a sprinkler head wrench for the sprinkler heads located throughout the facility. Interview, on 05/09/13 at 3:23 PM, with the Maintenance Supervisor revealed he was not aware the wrench was removed from the storage box. Reference: NFPA 13 (1999 edition) 6.2.9.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed.	K 062	The Facility Maintenance Director ordered a sprinkler head wrench for the sprinkler heads located throughout the facility on 5/29/13. The Maintenance Director was re-educated by the Property Manager on 5/14/13 regarding the requirement to maintain a sprinkler head wrench. The Maintenance Director will conduct a monthly audit to validate the center has a sprinkler head wrench for the sprinkler heads located throughout the facility. The Maintenance Director will report findings to the Performance Improvement Committee for three months for further recommendations. Completion Date 06/12/13		
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2	K 068			

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K 068	Continued From page 21 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and water heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for fifty (50) beds with a census of fifty (50) on the day of the survey. The findings include: Observation, on 05/09/13 at 3:21 PM, with the Maintenance Supervisor revealed fresh air vents in the furnace room located in the Front Hall were open to the attic and not vented to the outside. Interview, on 05/09/13 at 3:21 PM with the Maintenance Supervisor revealed he was unaware the vents were open to the attic. Reference: NFPA 101 Life Safety Code (2000 edition) Section 19.5 Building Services 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or	K 068	The Facility Maintenance Director vented the furnace room located in the Front Hall to the outside on 5/30/13. The Maintenance Director conducted a facility wide audit to validate that combustion and ventilation air for boiler incinerator and heater rooms was vented outside on 4/9/13; no other areas were identified. The Maintenance Director was re-educated by the Property Manager on 5/14/13 regarding combustion and ventilation air for boiler incinerator and heater rooms was vented outside. The Maintenance Director will conduct monthly audits of combustion and ventilation air for boiler incinerator and heater rooms monthly for three months to validate they are vented outside. The Maintenance Director will report findings to the Performance Improvement Committee three months for further recommendations. Completion Date 06/12/13	

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K 068	Continued From page 22 vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 068			
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cooking facilities were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, patients, staff, and visitors. The facility is certified for fifty (50) beds with a census of fifty (50) on the day of the survey. The facility failed to ensure the manual activation pull for the hood suppression was located in the egress path and readily accessible. The findings include: Observation, on 05/09/13 at 3:00 PM, with the Maintenance Supervisor revealed the manual activation pull for the facilities hood suppression system was not readily accessible due to the pull not being located in the path of egress. Further observation revealed it was unknown if the manual hood suppression system was connected to the gas line to stop the flow of gas upon activation.	K 069	The Facility Maintenance Director obtained a bid on 5/22/13 to move the manual activation pull for the kitchen's hood suppression system to be readily accessible area and on a path of egress. No other areas are affected. An agreement has been implemented with a vendor to move the manual activation pull for the facilities hood suppression system to a readily accessible area at a path to egress on 5/31/13; work will be completed as allowed by the vendor's schedule. The Maintenance Director was re-educated by the Property Manager on 5/14/13 regarding NFPA standards related to cooking facilities. The Maintenance Director will conduct a monthly audit for three months to validate the hood suppression system pull station for the hood suppression system is readily accessible on a path to egress. The Maintenance Director will report findings to the Performance Improvement Committee for three months for further recommendations. Completion Date 06/12/13		

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K 069	<p>Continued From page 23</p> <p>Interview on 05/09/13 at 3:00 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for the hood suppression manual pull station.</p> <p>Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.</p> <p>Reference NFPA 101 (2000 Edition) 19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3. Exception*: Where domestic cooking equipment is used for food-warming or limited cooking, protection or segregation of food preparation facilities shall not be required.</p>	K 069			

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K 069	<p>Continued From page 24</p> <p>9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 96</p> <p>11.4 Cleaning of Exhaust Systems. 11.4.1 Upon inspection, if found to be contaminated with deposits from grease-laden vapors, the entire exhaust system shall be cleaned by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Section 11.3. 11.4.2* Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal prior to surfaces becoming heavily contaminated with grease or oily sludge. 11.4.3 At the start of the cleaning process, electrical switches that could be activated accidentally shall be locked out. 11.4.4 Components of the fire suppression system shall not be rendered inoperable during the cleaning process. 11.4.5 Fire-extinguishing systems shall be permitted to be rendered inoperable during the cleaning process where serviced by properly trained and qualified persons in accordance with Section 11.3. 11.4.6 Flammable solvents or other flammable cleaning aids shall not be used. 11.4.7 Cleaning chemicals shall not be applied on fusible links or other detection devices of the</p>	K 069		

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K 069	<p>Continued From page 25</p> <p>automatic extinguishing system.</p> <p>11.4.8 After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance.</p> <p>11.4.9 All access panels (doors) and cover plates shall be replaced.</p> <p>11.4.10 Dampers and diffusers shall be positioned for proper airflow.</p> <p>11.4.11 When cleaning procedures are completed, all electrical switches and system components shall be returned to an operable state.</p> <p>11.4.12 When a vent cleaning service is used, a certificate showing date of inspection or cleaning shall be maintained on the premises.</p> <p>11.4.13 After cleaning is completed, the vent cleaning contractor shall place or display within the kitchen area a label indicating the date cleaned and the name of the servicing company, and areas not cleaned.</p> <p>11.4.14 Where required, certificates of inspection and cleaning shall be submitted to the authority having jurisdiction.</p> <p>Reference NFPA 96</p> <p>11.3 Inspection of Exhaust Systems. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Table 11.3.</p> <p>Table 11.3 Exhaust System Inspection Schedule Type or Volume of Cooking Frequency Frequency Systems serving solid fuel cooking operations Monthly</p>	K 069		

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K 069	Continued From page 26 Systems serving high-volume cooking operations such as 24-hour cooking, charbroiling, or wok cooking Quarterly Systems serving moderate-volume cooking operations Semiannually Systems serving low-volume cooking operations, such as churches, day camps, seasonal businesses, or senior centers Annually	K 069		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility is certified for fifty (50) beds with a census of fifty (50) on the day of the survey. The facility failed to maintain proper use of power strips, and ground fault receptacles. The findings include: Observations, on 05/09/13 between 10:30 AM and 4:00 PM, with the Maintenance Supervisor revealed the Hydrocollator located in the Therapy Office was not plugged into a ground fault (GFCI) protected outlet. Further observation revealed a refrigerator was plugged into a power strip located in room #10.	K 147	The Facility Maintenance Director immediately unplugged the Hydrocollator in the Therapy Office and removed the refrigerator plug from the power strip in room #10 on 5/9/13. A facility audit was conducted to identify if any other equipment required a GFCI protected outlet; any identified areas were corrected. The Hydrocollator outlet was changed to a GFCI outlet on 5/30/13. A facility audit was conducted to determine if any refrigerators were plugged into a power strip; any identified areas were corrected immediately. The Maintenance Director was re-educated by the Property Manager on 5/14/13 regarding electrical wiring and equipment in accordance with NFPA standards. The Maintenance Director will conduct monthly audits for three months to validate equipment which requires GFCI outlets has a proper plug. Audits will also be conducted monthly to validate power strips are not used for refrigerators. Audits will be completed for three months. The Maintenance Director will report findings to the Performance Improvement Committee for three months for further recommendations. Completion Date 06/12/13	

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K 147	<p>Continued From page 27</p> <p>Interview, on 05/09/13 between 10:30 AM and 4:00 PM, with the Maintenance Supervisor revealed he was not aware the Hydrocollator was to be plugged into a GFCI outlet. Further interview revealed he was not aware of the power strip being misused.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference NFPA 70 (1999) edition National Electric Code, relating to ground fault protection for electric outlets near sinks in resident rooms. NFPA: 70 210.8 Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G). (6) Kitchens - where the receptacles are installed</p>	K 147		

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K 147	Continued From page 28 to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink. Reference NFPA 70 (1999 edition) 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel. FPN: See 215.9 for ground-fault circuit-interrupter protection for personnel on feeders. (A) Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Garages, and also accessory buildings that have a floor located at or below grade level not intended as habitable rooms and limited to storage areas, work areas, and areas of similar use Exception No. 1: Receptacles that are not readily accessible. Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Receptacles installed under the exceptions to 210.8(A)(2) shall not be considered as meeting the requirements of 210.52(G). (3) Outdoors Exception: Receptacles that are not readily accessible and are supplied by a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of	K 147			

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K 147	Continued From page 29 Article 426. (4) Crawl spaces - at or below grade level (5) Unfinished basements - for purposes of this section, unfinished basements are defined as portions or areas of the basement not intended as habitable rooms and limited to storage areas, work areas, and the like Exception No. 1: Receptacles that are not readily accessible. Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Exception No. 3: A receptacle supplying only a permanently installed fire alarm or burglar alarm system shall not be required to have ground-fault circuit-interrupter protection. Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G). (6) Kitchens - where the receptacles are installed to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink. (8) Boathouses (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1), (2), and (3) shall have ground-fault circuit-interrupter protection for personnel: (1) Bathrooms (2) Rooftops Exception: Receptacles that are not readily accessible and are supplied from a dedicated	K 147			

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K 147	Continued From page 30 branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426. (406.8 Receptacles in Damp or Wet Locations. (A) Damp Locations. A receptacle installed outdoors in a location protected from the weather or in other damp locations shall have an enclosure for the receptacle that is weatherproof when the receptacle is covered (attachment plug cap not inserted and receptacle covers closed). An installation suitable for wet locations shall also be considered suitable for damp locations. A receptacle shall be considered to be in a location protected from the weather where located under roofed open porches, canopies, marquees, and the like, and will not be subjected to a beating rain or water runoff. (B) Wet Locations. (1) 15- and 20-Ampere Outdoor Receptacles. 15- and 20-ampere, 125- and 250-volt receptacles installed outdoors in a wet location shall have an enclosure that is weatherproof whether or not the attachment plug cap is inserted. (2) Other Receptacles. All other receptacles installed in a wet location shall comply with (a) or (b): (a) A receptacle installed in a wet location where the product intended to be plugged into it is not attended while in use (e.g., sprinkler system controller, landscape lighting, holiday lights, and so forth) shall have an enclosure that is weatherproof with the attachment plug cap inserted or removed. (b) A receptacle installed in a wet location where the product intended to be plugged into it will be attended while in use (e.g., portable tools, and so forth) shall have an enclosure that is	K 147			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185167	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/09/2013
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 147	Continued From page 31 weatherproof when the attachment plug is removed. (C) Bathtub and Shower Space. A receptacle shall not be installed within a bathtub or shower space. 3) Kitchens	K 147			