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

PRINTED: 05/14/2015
FORM APPROVED
OMB NO. 0938-0391

RECEIVED MAY 2015 OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185343		05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON'S CONVALESCENT CENTER	115 CAYCE ST HOPKINSVILLE, KY 42240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was conducted on 05/03/15 through 05/05/15 with deficiencies cited at the highest Scope and Severity of a "F".	F 000	**COVINGTON'S CONVALESCENT CENTER, INC.** acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary and findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of the resident. **COVINGTON'S CONVALESCENT CENTER, INC.'S** response to the statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is totally accurate.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure one (1) of fifteen (15) sampled residents (Resident #6) received the necessary care and services to prevent pressures sores. Staff failed to notify Licensed Practical Nurse (LPN) #1/Quality Assurance (QA) Skin Nurse of a change in Resident #6's skin integrity. The findings include: Review of the facility policy titled, "Pressure Ulcer Assessment and Treatment Skin Integrity, dated 12/26/11, revealed a resident with a break in skin integrity will receive clinically appropriate, currrently accepted standards of care. Visual wound assessments will be performed daily in-coordination with treatments (or as ordered by	F 314	**F 314** **483.25(c) TREATMENT\SERVICES TO PREVENT\HEAL PRESSURE SORES** **Corrective Action:** The facility skin nurse (LPN #1) was made aware of the skin issue to resident #6 on 5-5-2015. The skin blister to Res #6's heel was **actually not** present prior to 5/5/2015. Cna #1 was educated on proper reporting protocol for new skin issues by LPN #1 on 5/5/2015. Identify Others: Skin nurse (LPN #1) has performed skin audits on all residents in the facility on 5/5/2015 & 5/6/15 and again 5/12/15 & 5/13/15 to ensure that all present skin	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Asst. Administrator | (X6) DATE: 5-22-15

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

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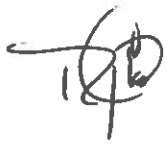
F 314	Continued From page 1 physician to coordinate treatments. Record review revealed the facility admitted Resident #6 on 10/13/09 with diagnoses which included Cerebrovascular Accident, Coronary Artery Disease, Senile Dementia, Right Hemiplegia, and Insulin Dependent Diabetes Mellitus. Review of a Significant Change Minimum Data Set (MDS) assessment, dated 03/31/15 revealed the facility assessed Resident #6's congition as severely impaired and the resident required total assist with activities of daily living and was at risk for pressure sores. Review of the Quik Reference Care Card utilized by the Certified Nurse Aides (CNA"S)for Resident #6 revealed to observe for signs and symptoms of skin breakdown and report if noted to the nurse. Review of the April 2015 Treatment Administration Record (TAR) revealed the last skin assessment was conducted on 04/29/15 with no skin issues identified. Observation of a skin assessment for Resident #6 with LPN #1 and Certified Medication Technician (CMT) #1, on 05/0515 at 11:00 AM, revealed three (3) discolorations on the resident's mid-back. LPN #1 identified the areas were non-stageable deep tissue injuries measuring 0.8 centimeter (cm.) by 2.0 cm., 0.7 cm. x 2.4 cm, and 0.4 cm. x 4.0 cm. In addition, there was a 4.0 cm. by 4.0 cm. stage II blister to the left heel. Interview with Certified Nurse Aide (CNA) #1, on 05/05/15 at 11:20 AM, revealed the blister was not there on Sunday (05/03/15). CNA #1 stated she was not aware of the areas to the resident's	F 314	 issues are noted and recorded appropriately. Systemic Changes: Re-education of all Cna's\Na's on proper reporting of new skin issues was conducted on 5/5/2015, 5/6/2015, & 5/7/2015 by DON and\or LPN #1. Treatment nurse will perform daily skin checks for Resident #6 to ensure that any new skin issues are noted timely. Starting 5/20/2015; while she is on comfort care\end of life issues. Monitoring: Resident #6 will be checked each day for any new or worsening skin issues by a licensed nurse on duty as long as Resident #6 is on "end of life care" starting 5/20/2015. Recordings will be on Resident #6's treatment record. Any resident with "end of life care" in place will be assessed daily by a licensed nurse or skin nurse for any changes in skin integrity. This will be noted on that residents TAR starting 5/20/2015. We currently have only two (2) residents in this category and they are on this new listing. Re-education for Cna's\Na's on proper reporting of new skin issues will be reviewed with them "twice a week for one week; repeat again the next week and then	



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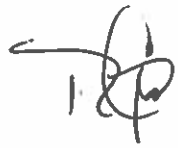
F 314	Continued From page 2 back but she had seen the blister on the left heel when she put Resident #6's socks on that morning (05/05/15) and had not told anyone. CNA #1 revealed another CNA had said the blister was there yesterday and the CNA had said she had told the charge nurse. CNA #1 stated she did no know the CNA's name. Interview with LPN #1/QA Nurse, on 05/05/15 at 11:22 AM and 1:55 PM, revealed she completed skin assessments every week and the blister was not there last week when the skin assessment had been completed. LPN #1/QA Skin Nurse stated whoever put the resident's socks on should have told LPN #1 about the blister on his/her left heel. LPN #1/QA Skin Nurse revealed staff put the socks on him/her daily and as needed and she would expect them to see the blister and tell someone. LPN #1/QA Nurse stated staff did not come and tell her about Resident #6's skin. Interview with the Director of Nursing (DON), on 05/05/15 at 1:35 PM, revealed any abnormality in the skin should be reported to the charge nurse and LPN #1/QA nurse immediately as soon as found.	F 314	Page 3 of 9 again in one month" for reinforcement. This re-education will be completed by the DON\designee or Skin Nurse. Completion Date: 5/21/15	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	**F 431** **483.60 (b), (d), (e) DRUG RECORDS, LABEL\STORE DRUGS & BIOLOGICALS** Corrective Action: 1. On 5/3/2015, DON placed insulin, insulin syringes, and said supplies on a locked cart within a designated drawer just for those supplies. 2. On 5/5/2015, Administrative RN in-serviced CMT 1 & CMT 2 on proper procedure for locking medication cart. Identify Others: 1. The complete remedy was met by having all Insulin\supplies placed on a locking cart on 5/3/2015 by DON. 2. All staff responsible for medication pass were re-educated on proper protocol for locking the medication cart when not	



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F 431	Continued From page 3 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies and procedures, it was determined the facility failed to store all medications and biologicals in locked compartments. Observations revealed an unlocked medication cart not in staff's sight and an open-sided, unlocked, rolling, metal utility cart, used for obtaining glucometer readings and administering insulins that had opened boxes of insulins,	F 431	 attended or out of line of sight. Re-education initiated 5/5/2015 and completed on 5/7/2015 by the DON. Systemic Changes: 1. Insulin supplies will be kept on a locked cart during insulin administration times from 5/3/2015 forward. 2. CMT 1 & 2 were inserviced on proper protocol for locking medication cart when unattended or not in the line of sight on 5/5/2015 by Administrative RN. Monitoring: 1. Insulin and supplies for insulin administration have been on a locked cart since 5/3/2015. The DON\ or charge nurse\ or Administrative RN have been making rounds daily to ensure insulin cart is being utilized and locked appropriately. Monitoring daily has taken place 5/3/2015 to 5/18/2015. No problems have been noted. Using the locked insulin cart has been **successful**. Monthly spot checks for proper protocol regarding locked insulin	

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F 431	Continued From page 4 multiple packs of syringes and lancets that were left unsupervised on the hallways. Interview on 05/05/15 at 10:15 AM, with Minimum Data Set Nurse #1, revealed there were eleven (11) residents in the facility with a history of wandering and wore wanderguards. The findings include: Review of the facility's policies and procedures titled, "Storage of Medications" not dated and "Best Practice Guidelines for Nursing on Insulin Administration" modified date 05/05/15, revealed medications carts and medication supplies were to be locked or attended by person with authorized assess. 1. Observation, on 05/03/15 at 10:00 AM, revealed Registered Nurse (RN) #1 was standing at a metal utility non-locking cart in the hallway outside a resident room. Atop the cart was multiple vials of insulin with syringes on the second shelf. Further observation revealed she drew up insulin, turned from the cart and entered the resident room leaving the cart out of site and unattended and insulin unsecured. Observation on 05/03/15 at 11:20 AM revealed RN #1 in the hallway with a metal utility non-locking cart containing insulin vials, syringes and a binder. Further observation revealed RN #1 applied gloves, drew up insulin in a syringe, then left the cart going into a resident's room. RN #1 turned her back to the cart and administered the resident's insulin leaving the cart out of site and unattended and insulin unsecured. Interview with Licensed Practical Nurse #1, on 05/05/15 at 7:45 AM, revealed the facility had	F 431	 cart will be completed by DON or designee for the next 2 months. 2. CMT 1 & CMT 2 were observed 5/5/15 to ensure that proper locking of medication cart procedures were followed. CMT #2 and Administrative RN revisited proper medication cart locking protocols on 5/12/15 as another reinforcement of protocol. Medication pass observation will be completed by DON or designee to ensure proper locking of medication carts is being practiced. This monitoring will be done once per week for one month; and one random spot check for the next two consecutive months. Facility's Pharmacy consulting LPN will be onsite 5/22/2015 to re-inservice and assess staff on insulin administration in regards to the new locked cart protocols and proper medication cart locking protocols. Completion date: 5/22/15	

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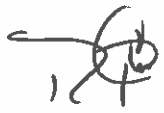
F 431	Continued From page 5 used the open cart to administer insulins for years. The second tray on the cart held eight (8) bags of insulin syringes and each bag had approximately ninety (90) syringes. There were seven (7) bags with each Diabetic resident's name on the bag and an extra bag of syringes from stock. The top of the cart held boxes with each resident's insulins and the glucometer, lancets and the bleach solution cleaner. Interview with the Director of Nursing (DON), on 05/05/15 at 8:45 AM, revealed the DON was aware of this distribution of insulin and supplies and also stated this had been a long standing practice. However, she was aware of the need to secure all medications in a locked storage container and to limit access to authorized personnel and stated this situation would be rectified. 2. Observation on 05/05/14 at 7:47 AM, revealed a medication cart in the hallway, outside a resident's room unlocked and unattended. At 7:50 AM, Certified Medication Technician (CMT) #1 and CMT #2 returned to the unlocked medication cart. Interview, on 05/05/15 at 7:47 AM with CMT #1 and CMT #2, revealed they were passing medications together from the cart. CMT #1 and CMT #2 stated CMT #2 was in orientation and CMT #2 had pulled medications from the cart but CMT #1 was responsible for the keys of this medication cart. Interview, on 05/05/15 at 11:12 PM with the Director of Nursing (DON), revealed she expected the medication cart and insulin to be locked at all times when not attended by the staff	F 431	 **F 441** **483.56 INFECTION CONTROL, PREVENT SPREAD** Corrective Action: 1. Dietary Aide noted in the deficient practice was re-educated on use of gloves or use of hand-sanitizer by DON on 5/4/2015 and all dietary employees were re-educated on same by the Dietary Manager on 5/5/2015. 2. NA #1 and all nursing employees that would pass meal trays were educated on proper protocol of using gloves\hand sanitizer for helping a resident with food, leaving resident room and returning and use of hand cleaner \ gloves. Education was completed by DON or LPN #1 (QA nurse) from 5/5/2015 through 5/7/2015. 3. Education on proper sanitizing of hands between patients was addressed with all nurse aides as they go in and out of resident rooms from 5/4/2015 through 5/7/2015 by the DON\LPN #1.	



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F 431	Continued From page 6 passing medications. Interview, on 05/05/15 at 1:55 PM with the Administrative Nurse, revealed she would expect all medications and carts to be locked up when not in direct site of the medication staff to ensure the safety of the medication at all times. She stated this should be the responsibility of the person responsible for the medication cart.	F 431	Page 7 of 9 Identify Others: 1. All dietary aides could potentially perform this practice, therefore, the complete remedy was met by re-educating proper techniques of passing meal plates to dining room residents. This inservice was conducted by the Dietary Manager on 5/5/2015. 2. And 3. Nurse aides passing out resident trays in resident rooms could have potential for this practice, therefore, re-education for all nurse aides regarding use of gloves when handling resident foods and using hand sanitizer between residents as well as using hand sanitizer when leaving and returning to resident rooms was completed by DON 5/5/2015 through 5/7/2015.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

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F 441	Continued From page 7 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection evident by staff not washing hands during meal service. The findings include: Review of the facility's policy and procedure titled, "Infection Control", not dated, revealed staff should adhere to proper hand washing techniques in between each resident contact. Additionally, staff should protect resident to resident or personnel to resident spread of illness. 1. Observation on 05/03/15 at 12:06 PM, revealed one (1) dietary aide serving meals to residents in the dining area using vinyl gloves. She was observed to deliver plates directly from the steam table to the resident table. On eight (8)	F 441	Page 8 of 9 Systemic Changes: 1. Dietary Manager and\or DON (or designee) will monitor handling of plates during meals and proper hand sanitizing procedures as dining room residents are served their food plates on a planned inspection regimen (see monitoring for details). 2. Education for all nurse aides handling resident food trays was provided by DON or LPN #1 from 5/5/2015 through 5/7/2015 to ensure that they understood proper handling of resident food (applying jelly) with use of gloves. 3. Education for all nurse aides handling resident personal items, food items such as jelly and toast, leaving resident room to gather more supplies and must resanitize hands prior to handling resident needs. Education was completed by DON or LPN #1 on 5/5/2015 through 5/7/2015. FOAM IN – FOAM OUT policy and protocol is a new policy that we have put in place to help eliminate cross contamination issues. (See attached policy)	

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F 441	Continued From page 8 observations she entered the dining room from the kitchen and returned to dining room making contact with surfaces such as resident's body, furniture, serving tray of other residents, dirty dish washing area, and dry storage area utilizing the same pair of gloves. The Dietary Aide failed to sanitize her hands between residents during the meal pass or after touching items. There were a total of fourteen (14) residents being served in the dining area during the meal observation. Interview with the Director of Nursing (DON), on 05/04/15 at 7:45 AM, revealed she expected the staff to change gloves or use hand sanitizer between residents. The DON stated staff not adhering to this practice could lead to the spread of infection. 2. Observation, on 05/04/15 at 8:00 AM, revealed Nurse Aide (NA) #1 applied jelly on a resident's toast after rolling up the bed and positioning an unsampled resident. The NA failed to sanitize her hands prior to applying the jelly on the toast. Interview, on 05/04/15 at 8:00 AM with NA #1, revealed she should have washed her hands and then put her gloves on before touching the residents' food because of germs and the resident could get sick. 3. Observation, on 05/05/15 at 7:55 AM, revealed Certified Nurse Aide (CNA) #1 removed a tissue box, television remote, and cup from the over the bed table then placed the Unsampled resident's plate on the table. The CNA opened the biscuit and placed jelly on the biscuit barehanded without sanitizing her hands prior to touching the biscuit. CNA #1 then left the room to obtain sugar packets and returned and put sugar the resident's coffee without sanitizing her hands.	F 441	 Monitoring: 1. Dietary Manager \ or her designee and\or DON will observe and ensure that dietary aides passing out dinner plates from the kitchen sanitize hands between patients if applies and\or sanitizes their hands before re-entering the kitchen again. This program monitoring will be completed once a week for 2 weeks and again in one month x 2 cycles to ensure continuity of protocol. 2. And 3. DON or designee will monitor meal pass to residents in room to ensure gloves are worn if employee has to touch their food or apply jelly, etc to their food. This monitoring will also include proper use of hand sanitizer between residents and that the employee sanitizes hands going into a room and upon exiting the resident room. This monitoring will be completed once weekly x one month, then twice a month x 1 month, then once a month x 1 to ensure continuity. Completion date: 5/21/15	

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F 441	Continued From page 9 Interview, on 05/05/15 at 8:12 AM with CNA #1, revealed she should have washed her hands and gloved before putting jelly on the biscuit and washed and gloved hands before putting the sugar in coffee. Interview on 05/05/15 at 1:35 PM with Director of Nursing (DON), revealed she expected staff to wear gloves when placing jelly on a residents' toast or biscuit.	F 441		

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MAY 2015
OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185343		05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON'S CONVALESCENT CENTER	115 CAYCE ST HOPKINSVILLE, KY 42240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1962. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (211). SMOKE COMPARTMENTS: Six (6) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1962 and upgraded in 2009 with a new panel, with 27 smoke detectors and 25 heat detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1962. GENERATOR: Type II generator installed in 2013. Fuel source is Diesel. A Recertification Life Safety Code Survey was conducted on 05/05/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-two (72) beds with a census of fifty-nine (59) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	**COVINGTON'S CONVALESCENT CENTER, INC.** acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary and findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of the resident. **COVINGTON'S CONVALESCENT CENTER, INC.'S** response to the statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is totally accurate. **K 029 NFPA Life Safety Code Standard** **Corrective Action:** Linen Cart will be removed from 100 hall Breezeway and relocated into a designated linen approved storage area effective 5/22/2015 by Laundry Supervisor. **Identify Others:** This is a total remedy by removing the linen cart from 100 hall Breezeway as this was the only linen cart in a breezeway area.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Asst. Adm.	5-27-15

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

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NAME OF PROVIDER OR SUPPLIER COVINGTON'S CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 CAYCE ST HOPKINSVILLE, KY 42240	

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K 000 Continued From page 1

Fire).

Deficiencies were cited with the highest deficiency identified at Scope and Severity of an "F".

K 029 SS=D NFPA 101 LIFE SAFETY CODE STANDARD

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

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was fifty-nine (59).

The findings include:

Observation, on 05/05/15 at 1:20 PM, with the

K 000

Systemic Changes:

Removal of linen cart from 100 hall breezeway and relocated in the approved linen storage area completed by 5/22/2015 by Laundry Supervisor.

K 029

On 5/6/2015, Administration educated Maintenance supervisor on tag K029 and proper storage of linen carts inside of a hazardous storage area and not on the 100 hall or 100 breezeway.

Administration\DON educated CNA/NA's On linen cart removal from breezeway 5/20/15 through 5/22/2015. Administrative RN educated Laundry Supervisor 5/20/15 regarding removal of linen carts from breezeways.

Monitoring:

Nursing (Cna\Na) and Laundry staff were educated by Administration on 5/26/2015 on complete removal of linen carts from 100 hall\breezeway. Laundry staff will monitor 100 hall breezeway and control access to linen cart each shift to ensure no linen cart is left on 100 hall or 100 breezeway.

Completion Date: 5/27/15

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K 029 Continued From page 2

Maintenance Supervisor revealed a linen cart being stored outside of a hazardous storage room located in the 100 Hall Breezeway.

Interview, on 05/05/15 at 1:20 PM, with the Maintenance Supervisor revealed he was not aware the linen cart could not be stored outside of a hazardous storage room when the cart was not in use.

The census of fifty-nine (59) was verified by the Administrator on 05/05/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/05/15.

Actual NFPA Standard:

Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.

Reference: NFPA 101 (2000 Edition) 9.3.2.1 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

K 029

K 056 NFPA Life Safety Code Standard

Corrective Action:

Maintenance Supervisor coordinated a "bid and completion time frame" with Pennyrile Fire Safety to complete the new "sprinkled overhang" under the porch roof mentioned. This new sprinkling system evaluation and bid was completed 5-15-15 by Pennyrile Fire Safety and received 5/20/2015. The bid was approved by Administration 5/21/2015. Anticipated completion date by June 22, 2015.

Identify Others:

This is the only unsprinkled area noted on survey. No other overhangs are left unsprinkled.

Systemic Changes:

Unsprinkled porch roof at the rear of the facility building will be sprinkled as required.

On 5/6/2015, Maintenance supervisor and Administration assessed the facility

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K 029 Continued From page 3

(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 permitted to have nonrated, factory or field-applied
protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.

Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be
self-closing or automatic-closing in accordance with 7.2.1.8.2.

Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:
(1) Upon release of the hold-open mechanism, the door becomes self-closing.
(2) The release device is designed so that the

K 029 overhangs to ensure that all others were properly sprinkled according to K056 tag.

Administration educated Maintenance Supervisor relative to Life Safety tag K056 on 5/6/2015.

Monitoring:

All facility overhangs were assessed by Maintenance Supervisor 5/5/2015. No other roof areas are unsprinkled.

No new additions are planned.

Completion Date: 6/22/15

K 076 NFPA 101 LIFE SAFETY CODE STANDARD

Corrective Action:

Light switches in the Oxygen Storage area were relocated "above" the Five (5) foot minimum requirement along with complete removal of the receptacle on

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K 029	Continued From page 4 door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029	5/12/2015 by Means & Fort Electric Company. **Identify Others:** No other Oxygen Storage area exists in the facility. **System Changes:** Light Switches were relocated above the five (5) foot minimum requirement along with the complete removal of the receptacle by Means & Fort Electric Company on 5/12/2015.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 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, in	K 056	On 5/6/2015, Administration educated Maintenance Supervisor on tag K076 to ensure that light switches and receptacles are installed above the five (5) foot minimum requirement from the floor in the Oxygen storage room. **Monitoring:** The Oxygen Storage room requirement for the light switches to be located above the five (5) foot minimum from the floor was met on 5/12/2015 along with complete removal of the receptacle. No other Oxygen Storage area exists. No other light switch or receptacle is present in the Oxygen Storage area. **Completion Date:** 5/12/15	

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K 056	Continued From page 5 accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was fifty-nine (59). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems. The findings include: Observation, on 05/05/15 at 3:00 PM, with the Maintenance Supervisor revealed an unsprinklered porch roof across the back of the building facing the parking lot outside the Activity Breezeway Exit. The roof extended out forty-nine (49) inches and was approximately ninety (90) feet long. Interview, on 05/05/15 at 3:01 PM, with the Maintenance Supervisor revealed he had not noticed the roof was not sprinkler protected. The census of fifty-nine (59) was verified by the Administrator on 05/05/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/05/15. Actual NFPA Standard: Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	**K 144 NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Action:** Maintenance Supervisor under guidance of Vanguard Generator Services "relocated the battery charger for the generator onto the starter" instead of the charger to the battery. This was completed on 5/08/2015. **Identify Others:** There are no other generators. **System Changes:** Administration educated Maintenance Supervisor on K144 to ensure the generator battery charger was correctly connected to the starter and not the charger itself, on 5/6/2015. The battery for the generator was hooked up to the starter as Life Safety Code Required on 5/08/2015.	

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K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage was in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was fifty-nine (59). The findings include: Observation, on 05/05/15 at 4:35 PM, with the Maintenance Supervisor revealed a light switch and receptacle were installed below five (5) feet from the floor located in the Oxygen Storage Room. Interview, on 05/05/15 at 4:36 PM, with the	K 076	Page 7 of 7 **Monitoring:** There are no other generators powering the facility. Maintenance Supervisor will monitor the generator battery connection to the starter on a monthly basis starting 5/22/2015. **Completion Date:** 5/8/15	

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K 076	Continued From page 7 Maintenance Supervisor revealed he was not aware of the requirements for oxygen storage. The census of fifty-nine (59) was verified by the Administrator, on 05/05/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/05/15. Actual NFPA Standard: Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 8-3.1.11.2 Storage for nonflammable gases less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply	K 076		

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K 076	Continued From page 8 with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 9	K 144		

This STANDARD is not met as evidenced by:
Based on observation, and interview, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-two (72) beds with a census of fifty-nine (59) on the day of the survey.

The findings include:

Observation, on 05/05/15 at 4:00 PM, with the Maintenance Supervisor revealed the battery charger located inside the generator enclosure to keep the battery charged for the emergency generator was connected directly to the battery terminals.

Interview, on 05/05/15 at 4:01 PM, with the Maintenance Supervisor revealed he was not aware the battery charger could not be connected directly to the battery terminals.

The census of fifty-nine (59) was verified by the Administrator on 05/05/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/05/15.

Actual NFPA Standard:

Reference: NFPA 110 (1999 Edition) 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the

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K 144	Continued From page 10 manufacturers ' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144		