

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/21/2013
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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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(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
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F 000	INITIAL COMMENTS  A recertification survey was conducted on 02/19/13 through 02/21/13 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 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.	
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, and review of the facility's policy it was determined the facility failed to ensure privacy and dignity for one resident (#17), not in the selected sample. Observation of peri-care for Resident #17 revealed the Certified Nurse Aide (CNA) failed to pull the privacy curtain and provided care in full view of the resident's roommate.  A review of the facility policy titled "Right to Privacy - Dignity and Confidentiality", dated 12/06/01, revealed all staff must ensure that during activity of daily living (ADL) care, treatments, and Physician or family visits a residents privacy and dignity are fully protected. In addition, facility staff shall examine and treat residents in a manner that maintains full privacy of their bodies. During daily care staff shall ensure that drapes, privacy curtains, and hallway	F 241	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.  <b>F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b>  <b>Corrective action:</b> On the day of the survey, CNA #3 was immediately counseled regarding the right to privacy and dignity during ADL care relative to resident #17. A meeting was conducted by the director of nurses with all Licensed Nurses, CNA's, and miscellaneous department staff members on duty to be sure that the right to privacy and dignity were being observed during ADL care. All CNA's shall ensure, as much as is practicable, the residents privacy and confidentiality with respect to their ADL care, personal care, treatments, visitation meetings with family and physician, and resident groups. An in-service was scheduled on 02/22/13, 02/23/13, and 02/24/13 reinforcing the privacy policy of Covington's	

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

TITLE

Adm

(X6) DATE

4-04-13

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	Continued From page 1 doors are utilized in such a way as to eliminate exposure of bodies from public view.  The findings include:  Observation of peri-care for Resident #17, on 02/19/13 at 11:15 AM, revealed CNA #3 provided peri-care in full view of Resident #17's roommate. The CNA failed to pull the privacy curtain when providing peri-care.  Interview with CNA #3, on 02/19/13 at 12:30 PM, revealed she failed to closed the privacy curtain when she provided peri-care to had not been closed when Resident #17 was being provided peri-care. CNA #3 stated Resident #17 was completely exposed during peri-care to the roommate.  Interview with the Director of Nursing (DON), on 02/21/13 at 4:15 PM, revealed staff should pull the privacy curtain between the residents in the rooms when peri-care is being provided.	F 241	Convalescent Center. All staff members must ensure that a resident's privacy and dignity are fully protected during ADL care. The facility staff should treat residents in a manner that fully maintains their privacy during daily ADL care. The staff must close drapes, privacy curtains, and hallway doors to eliminate the exposure from public view and/or from the view of a roommate. All hallway doors must be closed and privacy curtains utilized, as indicated, to eliminate exposure during bed bathing, treatments, and whirlpool operations. Visitors are also expected to observed facility policies relative to privacy and dignity of the residents.  <b>Identify others:</b>  All residents receiving ADL, whether bathing, dressing, grooming, or other personal care within the facility have the potential to be affected by this practice if the appropriate policy and procedure for privacy and dignity are not followed.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280	<b>Systemic changes:</b>  Staff education and in-services were conducted by the Director of Nurses, RN, on 2/22/13 and will be performed regularly, annually, periodically, and as needed for Licensed Nurses, CNA's, miscellaneous department assistants, and rehab staff to ensure that all staff members are advised of the standard nursing practices and of the facility policy and	

Page 2 of 18

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F 280	Continued From page 2 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and review of the facility's policy it was determined the facility failed to revise the care plan for one resident (#7), in the selected sample of 15. The facility failed to revise the care plan when Resident #7 was assessed as in need of a saddle cushion to his/her wheelchair to prevent falls.  The findings include:  A review of the facility's Care Plan Policy, no date, revealed care plans should be revised as changes in the resident's condition dictate and care plans should be reviewed at least quarterly.  A record review revealed Resident #7 was re-admitted to the facility on 01/14/13 with diagnoses to include Altered Mental Status, Dementia with Behavioral Disturbances, Cardiovascular Accident with left sided weakness, Arthritis and Neuropathy.  An observation of Resident #7, on 02/19/13 at 11:45 AM, revealed the resident was sitting in a	F 280	<p style="text-align: right;">Page 3 of 18</p> <p>procedures regarding resident privacy and dignity. The policy and procedure will be updated and reinforced with all facility staff members when hired, periodically, and/or annually thereafter. Reminder notices were scheduled and posted to the "Nursing Care Tracker" patient monitoring and care documentation system on 03/12/13 through 3/22/13 to remind CNA's of the privacy and dignity facility policy. The reminder notice states "always provide your patient's with privacy and dignity. Do not expose a patient during bathing and grooming. Always close privacy curtains between residents. Close the drapery curtains to the windows in order to not expose the resident to someone in the yard or parking lot. Speak softly to your residents about their care and concerns in order to not expose their illnesses, treatments, and other conversations to visitors in the room or hallway." These notices must be acknowledged by the Nurses and CNA's and attested to by their documentation as recognition of and use of this policy.</p> <p><b>Monitoring:</b></p> <p>The Continuous Quality Improvement CQI program will include documentation, as a portion of its Right to Privacy, Dignity, and Confidentiality Education Section of the Continuous Quality Improvement Policy and Protocol records. This will ensure that regular monthly and periodic observations and reports reflecting the</p>		

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F 280	Continued From page 3 high-back wheelchair with a saddle cushion in place beneath him.  A review of the Comprehensive Care Plan, dated 04/19/12, revealed there were no interventions to address a saddle cushion to Resident #7's wheelchair.  An interview with the Minimum Data Set (MDS) Coordinator, on 02/21/13 at 8:45 AM, revealed she failed to add the saddle cushion to the care plan.  An interview with the Director of Nursing (DON), on 01/21/13 at 10:24 AM, revealed it was the responsibility of the MDS Coordinator to update the care plans, as needed.	F 280	adherence to the policy of the facility are maintained. These minutes will reflect quarterly and periodic compliance reviews of the facility's policy and procedure for dignity and privacy. Actions that will be monitored will be as follows: 1. Staff providing ADL care to ensure a residents privacy and dignity are fully protected, 2. Staff shall examine and treat residents in a manner that maintains full privacy of their bodies, 3. Ensure that drapes, privacy curtains, and hallway doors eliminate exposure from public view, 4. Ensure residents are not exposed during bed bathing, ADL care, dressing, treatments, and/or whirlpool bathing, etc, 5. Staff must knock, ID one's self, and ask for permission, prior to entering resident rooms, 6. In-services will be conducted with new employees, periodically as needed, and annually with all employees on the policy and procedures relative to privacy and dignity of facility residents.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined that the facility failed to ensure two residents (#1 and #5) in the selected sample of fifteen, were provided care in accordance with the care plan. Resident #1 was care-planned for a wheel chair with anti-tippers/rollback device, and was put in a wheelchair without	F 282	The Director of Nurses, RN, Administrative Assistant, RN, and/or their designee will perform the visual monitoring and report the tabulated results to the CQI committee regularly, periodically, and monthly. The monthly	

Page 4 of 18

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F 282	<p>Continued From page 4</p> <p>anti-tippers/rollback devices which resulted in a fall with no injury. Resident #5 was care-planned for a bed alarm after a fall and observations revealed there was no bed alarm in place.</p> <p>The findings include:</p> <p>1. A review of the facility's Care Plan Policy, no date, revealed each resident's comprehensive care plan has been designed to incorporate risk factors associated with identified problems and aid in preventing or reducing declines in the resident's functional status and/or functional levels.</p> <p>A record review revealed Resident #5 was admitted to the facility on 11/13/08 with diagnoses to include Hypotension, Hyperglycemia, End Stage Congestive Heart Failure, and Alzheimer's Dementia.</p> <p>A review of the quarterly Minimum Data Set assessment, dated 01/15/13, revealed the facility assessed Resident #5 as having severe cognitive impairment and ambulated with minimal assistance with walker.</p> <p>A review of the Comprehensive Care Plan for "At Risk for Falls and Injury", dated 11/04/10, revealed an intervention for a bed alarm while in bed and to check for proper functioning.</p> <p>Observations on 02/20/13 at 12:10 PM, 1:40 PM and 3:00 PM revealed Resident #5 was laying in bed with a pressure alarm pad under the resident with the wiring coming out and no alarm box hooked to the end of the wire.</p>	F 282	<p>meeting will be conducted by the Asst. Administrator and/or the Adm. Assistant RN, and will include any issues discovered during observation and evaluations, needed corrections, retraining, if necessary, and overall results for the committee to evaluate and review.</p> <p>Progressive discipline shall continue with staff members out of compliance with the facility privacy and dignity policy, that will reinforce in-services for retraining, and policy reviews to re-educate staff members. This discipline will continue up to and including discharge from employment. The retraining sessions will be conducted by the Director of Nurses, RN, and/or the Adm. Asst. RN., and/or their Designee.</p> <p>Completion date: 3/29/13</p> <p><b>F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b></p> <p><b>Corrective action:</b> On the day of the survey, 02/21/13, resident #7's care plan was reviewed and revised in order to include documentation attesting to the need for a saddle cushion for the residents wheelchair to prevent falls. The saddle cushion was utilized as a positioning device and the care plan reflects that the initiation of its use on 07/19/10. Routine and regular reviews and updates of the resident care plans were performed and revised every 90 days. A</p>		

Page 5 of 18

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F 282	Continued From page 5  An interview with Certified Nurse Aide (CNA) #5, on 02/20/13 at 3:10 PM, revealed there was no alarm box hooked up to the pressure alarm pad.  Interview with CNA #1, on 02/20/13 at 3:15 PM revealed she did not know where the alarm box was, and when the bed was made up the alarm did not go off.  Interview with the Minimum Data Set (MDS) Coordinator, on 02/20/13 at 3:25 PM, revealed Resident #5 should have a functioning bed alarm to bed.  Interview with the Director of Nursing (DON), on 02/21/13 at 4:15 PM, revealed when a resident is care planned for an alarm she expected the alarm to be in place.  2. A record review revealed Resident #1 was admitted to the facility on 01/14/11 with diagnoses to include Dementia, Hypertension, Intercranial Hemorrhage and Transischemic Attacks.  A review of the Minimum Data Set (MDS) quarterly assessment, dated 01/15/13, revealed the facility assessed Resident #1 as severely cognitively impaired, required extensive assistance with all activities of daily living, and was a high risk for falls. Resident #1 was mobile per self in his/her wheelchair which was equipped with specialized anti-tipper and anti-rollback devices.  A review of Resident #1's record revealed he/she was at high risk for falls and had sustained falls which the facility had implemented care plan	F 282	review of the residents care plans revealed that the saddle cushion had been identified as an intervention on previous care plans and was inadvertently omitted during a recent update.  <b>Identify others:</b>  All residents identified with the need for special care devices to promote their well-being have the potential to be affected by the same practice if care plans are not maintained to identify the need for and use of such devices and reviewed and revised regularly every 90 days and as needed.  <b>Systemic changes:</b>  The policy and procedure for updating the and review of care plans for the facility residents will be modified to include maintaining a current list of Special Needs Devices utilized for the well-being of his residents. This list will include, but not be limited to, special cushions for positioning devices, anti-rollback/anti-tippers wheelchair devices, and other devices relative to the safety of the facility residents. This list will ensure the care plans are updated to reflect interventions relative to the use of these devices. The MDS and Care Plan coordinator will utilize this list to assist in monitoring the need for current updates of the relative care plans.  <b>Monitoring:</b>		

Page 6 of 18

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F 282	Continued From page 6 interventions to prevent reoccurrence. Anti-tippers and anti-rollback devices had been placed on Resident #1's wheelchair (exact date unknown) as an intervention.  A review of Resident #1's care plan titled HIGH RISK FOR FALLS, dated 12/31/08, revealed an interventions for anti-rollback and anti-tipper devices to wheel chair.  A review of the Nursing Notes, dated 09/30/12 at 5:00 PM, revealed Resident #1 sustained a fall when his/her wheelchair turned over. The resident was found on the floor with no visible injury. Review of the investigation of the fall revealed the resident's wheelchair had been removed from service for repair and the resident had been placed in another wheelchair that did not have the anti-tipper or anti-rollback device.  An interview with the Director of Nursing (DON), on 02/21/13 at 12:30 PM, revealed she had been unable to determine when Resident #1's wheelchair had been removed from service or by whom. The DON stated there was something bent on one of the anti-tippers and a staff had removed the wheelchair for repair. She was unable to determine who removed the wheelchair or when. The DON stated the resident's care plan for falls included the intervention of the anti-tipper and anti-rollback devices and when he/she had been placed into the chair without the anti-tipper and anti-rollback devices the care plan was not being implemented.	F 282	The Continuous Quality Improvement CQI program will include documentation, as a portion of the need for the use of Special Devices Section of the Continuous Quality Improvement Policy and Protocol records. This will ensure that regular monthly and periodic observations and reports reflecting the adherence to the policy of the facility are maintained. These minutes will reflect quarterly and periodic compliance reviews of the facility's policy and procedure for the use of the devices and that the documentation of the same is regularly maintained within the care plan.  The MDS and Care Plan Coordinator will monitor the use of and maintain a current listing of Special Needs Devices utilized by facility residents. This will include, but not be limited to, instruction procedures for use and training to implement and maintain the following comfort and safety devices:  1. Anti-tipper and anti-roll-back wheelchair devices, 2. Fall mattresses, 3. Bed and chair alarms, 4. Wander guard monitoring devices, 5. Saddle Cushions, 6. Bolster Cushions.  The Care Plan Coordinator and/or her designee will check the list against the current care plans quarterly and monthly to ensure all devices utilized by residents are care planned accordingly and ensure that the list reflects all currently used devices within the facility.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident	F 323		

Page 7 of 18

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F 323	<p>Continued From page 7</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy it was determined the facility failed to ensure residents received assistive devices to prevent accidents for two residents (#1 and #5), in the selected sample of fifteen residents and one resident (#16), not in the selected sample. Resident #1 was care planned for anti-tippers/rollback devices to wheelchair and was placed in a wheelchair without these devices which resulted in the wheelchair turning over and the resident sustaining no injuries. Resident #5 was care planned for a pressure alarm to bed and the pressure alarm to bed had no alarm box in place. Resident #16 was transferred with a sit to stand lift to bedside commode with one staff assist when it was the facility's policy to use two staff assist for safety. In addition, thirteen rooms were determined to have combustibles on over bed wall lights which was a fire hazard.</p> <p>The findings include:</p> <p>1. An interview with the DON, on 02/21/13 at 2:00 PM, revealed there was no policy related to damaged equipment.</p> <p>A record review revealed Resident #1 was</p>	F 323	<p style="text-align: right;">Page 8 of 18</p> <p>The Director of Nurses, RN, and/or the Care Plan Coordinator will implement proper usage of the device and maintain its use during the designation of the care plan. In-services will be conducted by the Director of Nurses, RN., the Adm. Asst. RN, and/or their designee, annually and as needed, concerning the proper utilization of the use of the safety devices. The quarterly CQI meetings will be conducted by the Asst. Administrator and/or the Adm. Assistant RN, and will include any issues discovered during observation and evaluations, needed corrections, retraining, if necessary, and overall results for the committee to evaluate and review. The CQI coordinator will identify and refer repetitive concerns to the Administrator for final resolution, should in-service and retraining not remedy the situation and violations.</p> <p style="text-align: right;">Completion date: <i>3/29/13</i></p> <p><b>F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p><b>Corrective action:</b></p> <p>Even though resident #1's temporary use of an alternative wheelchair had been corrected prior to 02/21/13, the facility had acquired an additional backup wheelchair with ant-Tipper's/rollback devices to be used in the event of need for service and/or repair of a chair currently in use.</p>		

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F 323	<p>Continued From page 8</p> <p>admitted to the facility on 01/14/11 with diagnoses to include Dementia, Hypertension, Intercranial Hemorrhage and Transischemic Attacks.</p> <p>A review of the Minimum Data Set (MDS) quarterly assessment, dated 01/15/13, revealed the facility assessed Resident #1 as severely cognitively impaired, required extensive assistance with all activities of daily living, and was a high risk for falls. Resident #1 was mobile per self in his/her wheelchair which was equipped with specialized anti-tipper and anti-rollback devices.</p> <p>A review of Resident #1's care plan titled HIGH RISK FOR FALLS, dated 12/31/08, revealed an interventions for anti-rollback and anti-tipper devices to wheel chair.</p> <p>A review of a nursing note, dated 09/30/12 at 5:00 PM, revealed Resident #1 sustained a fall when his/her wheelchair turned over. The resident was found in the floor with no visible injury. The resident was sent to the emergency room for evaluation at family request due to having a history of an Intercranial Hemorrhage in the past. He/she returned to the facility at 9:50 PM with no new orders.</p> <p>A review of the investigation of the fall, dated 09/30/12, revealed the resident had been placed in a wheelchair that was not equipped with the anti-tipper and anti-rollback devices due to his/her wheelchair being removed from service for repair. Resident #1 was found on the floor with the wheelchair overturned at 5:00 PM with no visible injury.</p>	F 323	<p>The pressure alarm pad relative to resident #5 was repositioned in proper working order on 2/20/13, as soon has the problem was identified. The review of the chart and the nursing record of resident #5 revealed that the resident would routinely disable the alarm in order to get out of bed without activating the alert. On 01/15/11, a bell was attached to resident #5's walker, secondary to noncompliance with the bed alarm, to alert the staff that the resident had disabled the bed alarm and was attempting to get up without assistance. The review of the residents quarterly updated care plans revealed the use of the bed alarm and the need for routine monitoring while the resident was in bed. Reminder notices were scheduled and posted to the "Nursing Care Tracker" patient monitoring and care documentation system on 03/12/13 through 3/22/13 to remind CNA's of the use of anti-Tipper/anti-rollback facility policy. The reminder notice states "the facility maintains it backup anti-Tipper/anti-rollback wheelchair in storage, do not place residents using this device in a wheelchair that is not so equipped." This list of Special Needs Devices will be reviewed by the MDS and Care Plan coordinator to ensure the care plans are updated timely and that the residents are monitored for the use of the devices.</p> <p><b>Identify others:</b></p> <p>All residents identified with the need for special care devices, such as, anti-</p>	

Page 9 of 18

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

PRINTED: 03/06/2013  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/21/2013
NAME OF PROVIDER OR SUPPLIER  COVINGTON'S CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 9</p> <p>An interview with the Director of Nursing (DON), on 02/21/13 at 12:30 PM, revealed she had been unable to determine when Resident #1's wheelchair had been removed from service or by whom. The DON stated there was something bent on one of the anti-tippers and a staff had removed the wheelchair for repair. She was unable to determine who removed the wheelchair or when.</p> <p>2. A record review revealed Resident #5 was admitted to the facility on 11/13/08 with diagnoses to include Hypotension, Hyperglycemia, End Stage Congestive Heart Failure, and Alzheimer's Dementia.</p> <p>A review of the quarterly MDS assessment, dated 01/15/13, revealed the facility assessed Resident #5 as severely cognitively impaired and was able to ambulate with minimal assistance with a walker.</p> <p>A review of the Comprehensive Care Plan for "At Risk for Falls and Injury", dated 11/04/10, revealed an intervention for a bed alarm while in bed and check for proper functioning.</p> <p>Observations on 02/20/13 at 12:10 PM, 1:40 PM, and 3:00 PM revealed Resident #5 was laying in bed with a pressure alarm pad under the resident with the wiring coming out and no alarm box hooked to the end of the wire.</p> <p>An interview with Certified Nurse Aide (CNA) #5, on 02/20/13 at 3:10 PM, revealed there was no alarm box hooked up to the pressure alarm pad.</p> <p>Interview with CNA #1, on 02/20/13 at 3:15 PM revealed she did not know where the alarm box</p>	F 323	<p>Page 10 of 18</p> <p>Tipper/anti-rollback and bed alarms, to promote their safety and well-being, have the potential to be affected by the same practice if care plans are not maintained to identify the need for and use of such devices and care be provided in accordance with the care plan.</p> <p><b>Systemic changes:</b></p> <p>The policy and procedure for updating the and review of care plans for the facility residents will be updated and modified to include maintaining a current list of special need devices utilized in the facility for the well-being of its residents. This list will include, but not be limited to, special cushions for positioning devices, anti-rollback/anti-tippers wheelchair devices, bed alarms, high back wheelchairs, and other devices relative to the safety and comfort of the facility residents. This list will be reviewed by the MDS and care plan coordinator to ensure the care plans are updated timely and that the residents are monitored for the use of the devices. The list will be posted in the nurses chartroom so nurses can observe the use of these devices daily.</p> <p><b>Monitoring:</b></p> <p>The Continuous Quality Improvement, CQI, program organized by the Asst. Administrator will include documentation, as a portion of the need for the use of Special Devices Section of the Continuous Quality Improvement Policy and Protocol</p>	

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

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F 323	<p>Continued From page 10</p> <p>was, and when the bed was made up the alarm did not go off.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 02/20/13 at 3:25 PM, revealed Resident #5 should have a functioning bed alarm to bed.</p> <p>Interview with the Director of Nursing (DON), on 02/21/13 at 4:15 PM, revealed when a resident is care planned for an alarm she expected the alarm to be in place.</p> <p>3. A review of the facility policy for mechanical lifts, no date, revealed the policy did not address the number of aides needed to operate the lift.</p> <p>Observation on 02/20/13 at 3:43 PM revealed Resident #16 was sitting on the bedside commode with a sit to stand lift in front of resident and Certified Nursing Assistant (CNA) #4 in the room.</p> <p>Interview with CNA #4, on 02/20/13 at 3:45 PM, revealed she had transferred Resident #16 to the bedside commode by herself with the sit to stand lift and she was about to transfer the resident back to the bed by herself.</p> <p>Interview with Resident #16, on 02/21/13 at 12:30 PM, revealed when staff transfer him/her with the lift sometimes there is two staff and sometimes there is one staff.</p> <p>Interview with CNA #1 and CNA #2 on 02/21/13 at 3:15 PM revealed there should be two staff when a resident is transferred with the sit to stand lift. The CNAs stated the facility teaches us to use</p>	F 323	<p>records. This will ensure that regular monthly and periodic observations and evaluations reflecting the adherence to the policy of the facility are maintained. These minutes will reflect quarterly and periodic compliance reviews of the facility's policy and procedure for the use of the special devices and that the documentation of the same are regularly maintained within the CQI records.</p> <p>The MDS and Care Plan Coordinator will monitor the use of and maintain a current listing of Special Devices utilized by facility residents. This will include, but not be limited to, the following comfort and safety devices:</p> <ol style="list-style-type: none"> <li>1. Anti-tipper and anti-roll-back wheelchair devices,</li> <li>2. Fall mattresses,</li> <li>3. Bed and chair alarms,</li> <li>4. Wander guard monitoring devices,</li> <li>5. Saddle Cushions,</li> <li>6. Bolster Cushions.</li> </ol> <p>The Care Plan Coordinator and/or her designee will check the list against the current care plans quarterly and monthly to ensure all devices utilized by residents are care planned accordingly and ensure that the list reflects all currently used devices within the facility.</p> <p>The Director of Nurses, RN, and/or the Care Plan Coordinator will implement proper usage of the device and maintain its use during the designation of the care plan.</p>	

Page 11 of 18

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 11 two assist.  Interview with Licensed Practical Nurse #2, on 02/21/13 at 3:50 PM, revealed when staff utilized lifts there was supposed to be two people.  Interview with the DON, on 02/21/13 at 4:15 PM, revealed two staff should assist when using the sit to stand lift.  4.) Interview with the Director of Nursing, on 02/21/13 at 12:30 PM, revealed there was no policy and procedure to address the storage of combustible materials on the over bed lights in residents' rooms.  Observation on 02/19/13 at 8:15 AM, on 02/20/13 at 8:10 AM, and on 02/21/13 at 3:00 PM revealed there were stuffed animals, pictures, cards, snow globes, figurines, glass and vases of flowers on the over the bed wall lights in rooms # 116, #118, #119, #120, #121, #123, #125, #127, #226, #227, #228, #230, and #232.  Interview with Registered Nurse (RN) #1, on 02/21/13 at 1:00 PM, revealed she was not aware of any information related to storing items on top of the over the bed lights.  Interview with the Director of Nursing, on 02/21/13 at 12:30 PM, revealed the lights always have stuff on them. She stated the residents and families place items on the lights and she has made compliance rounds in the past and removed the items. She revealed she has talked with the residents and families but they place the items back on the lights.	F 323	In-services will be conducted by the Director of Nurses, RN, and/or the Adm. Asst, RN, with new employees, when hired, and periodically as needed, and annually with all employees on the policy and procedures relative to initiating and utilizing Special Needs Devices by the facility residents. The quarterly CQI meetings will be conducted by the Asst. Administrator and/or the Adm. Assistant RN, and will include any issues discovered during observation and evaluations, needed corrections, retraining, if necessary, and overall results for the committee to evaluate and review. The CQI coordinator will identify and refer repetitive concerns to the Administrator for final resolution, should in-service and retraining not remedy the situation and violations.  Completion date: 3/29/13  <b>F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  Corrective action:  Even though resident #1's temporary use of an alternative means of mobility wheelchair had been corrected prior to 02/21/13, the facility acquired an additional backup wheelchair with anti-Tipper's/rollback devices to be used in the event of need for service and/or repair of a chair currently in use.	

Page 12 of 18

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 12 Interview with Maintenance Worker #1 and Maintenance Worker #2, on 02/21/13 at 4:10 PM, revealed that the wattage in the over the bed wall lights consisted of two 32 watt Super T8 bulbs.	F 323	<p style="text-align: right;">Page 13 of 18</p> <p>The pressure alarm pad relative to resident #5 was repositioned in proper working order on 2/20/13 as soon as the problem was identified. A review of the chart and nursing record of resident #5 revealed that the resident would routinely disable the alarm in order to get out of bed without activating the alert. On 01/15/11, a bell was attached to resident #5's walker, secondary to noncompliance with the bed alarm, to alert the staff that the resident had disabled the bed alarm and was attempting to get up without assistance. A review of the residents quarterly updated care plans revealed the use of the bed alarm and the need for routine monitoring while the resident was in bed.</p> <p>Reminder notices were scheduled and posted to the "Nursing Care Tracker" patient monitoring and care documentation system on 03/12/13 through 3/22/13 to remind CNA's of the use of anti-Tipper/anti-rollback facility policy. The reminder notice states "the facility maintains it backup anti-Tipper/anti-rollback wheelchair in storage, do not place residents using this device in a wheelchair that is not so equipped."</p> <p>The Assessment of resident #16 reveals that the individual is of limited assist and can weight-bear at least 20% of her total body weight, that the resident does have upper body trunk support, the resident weighs less than 400 pounds, and that there is a clear path to transfer the resident to her destination. The policy and procedure for use of the sit to stand lift has been revised to conform to the</p>		

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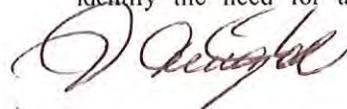
Page 14 of 18

manufacturer's guidelines for its use. The facility policy has been revised to state that the lift can be used by one or two CNA's, as indicated; which is supported by the assessment questions related to residents ability of limited assist or semi-dependent, having upper body support, with limited total weight. All CNAs which utilize the sit to stand lift will complete the skills check off list at in-service training and view the in-service videos provided by the manufacturer on 3/14/13 and 3/15/13. This in-service will be conducted by one of the CNA's in-service coordinators.

A survey of all resident rooms within the facility was conducted on the 02/22/13 to locate and address storage of combustible materials on the over bed lights within the resident rooms. Items were removed from the light fixture and residents were instructed not to store combustible items upon the light fixture. A letter was typed and mailed on 03/14/13 to notify the resident's family and/or guardian that these items could not be stored on the light fixtures.

**Identify others:**

All residents identified with the need for special care devices, such as, anti-Tipper/anti-rollback and bed alarms, to promote their safety and well-being have the potential to be affected by the same practice if care plans are not maintained to identify the need for and use of such



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Page 15 of 18

devices and the care be provided in accordance with the care plan.

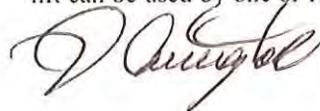
All residents identified with the need for use of the sit to stand lift have a potential to be affected by the same practice if CNA's are not properly trained for its use and understand that the lift can be applied by one or two assistants, as indicated.

All residents residing in the facility who store combustible items on the light fixture have the potential to be affected the same practice if not instructed to the proper facility policy and procedure concerning the storage of such items.

#### Systemic changes:

The policy and procedure for updating and review of care plans for the facility residents will be evaluated, updated and modified to include maintaining a current list of special need devices utilized in the facility for the well-being of his residents. This list will include, but not be limited to, special cushions for positioning devices, anti-rollback/anti-tippers wheelchair devices, bed alarms, high back wheelchairs, and other devices relative to the safety and comfort of the facility residents. This list will be reviewed by the MDS and care plan coordinator to ensure the care plans are updated timely and that the residents are monitored for the use of the devices.

The policy and procedures for utilizing the sit to stand lift for resident transfers will be modified and revised to express that the lift can be used by one or two CNA's, as is



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Business: (270) 886-4403

Fax: (270) 886-4406

Page 16 of 18

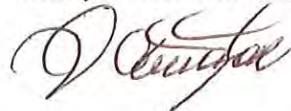
appropriate, in accordance with manufacturers videos for training and facility policy.

The policy and procedure for improper storage of combustible items upon light fixtures has been implemented and the facility residents have been counseled relative to its use.

#### Monitoring:

The Continuous Quality Improvement CQI program will include documentation, as a portion of the Special Devices Section, Sit to Stand Lift Section, and Improper Storage of Combustible Items Section of the Continuous Quality Improvement Policy and Protocol records. This will ensure that regular monthly and periodic observations and reports reflecting the adherence to the policy of the facility are maintained. These minutes will reflect quarterly and periodic compliance reviews of the facility's policy and procedure for the use of the special devices, sit to stand lift training, and improper storage of combustible items on light fixtures and that the documentation of the same is regularly maintained within the CQI minutes.

The Director of Nurses, RN, and/or MDS and Care Plan Coordinator will monitor the correct use of and maintain a current listing of Special Devices utilized by facility residents and those items that could contribute to accidents within the facility. This will include, but not be



# COVINGTON'S

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Business: (270) 886-4403

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Page 17 of 18

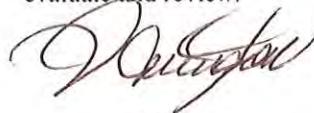
limited to, the following comfort and safety devices:

1. Anti-tipper and anti-roll-back wheelchair devices,
2. Fall mattresses,
3. Bed and chair alarms,
4. Wander guard monitoring devices,
5. Saddle Cushions,
6. Bolster Cushions,
7. Sit-to Stand Mechanical Lift,
8. Storage of combustible items on light fixtures.

The Director of Nurses, RN, and/or the In-service Coordinator will implement instructions for proper usage of the device and maintain correct usage to assist residents from sit-to-stand positions.

In-services were conducted by the Director of Nurses on 2/22/13 and will continue by her, and the In-service Coordinator, and/or their designee with new employees, when hired, and periodically as needed, and annually with all employees on the policy and procedures relative to initiating use and utilizing Special Needs Devices, Sit-to-Stand Lifts, and Storage of Combustible items within the resident's room.

The quarterly CQI meetings will be conducted by the Asst. Administrator and/or the Adm. Assistant RN, and will include any issues discovered during observation and evaluations, needed corrections, retraining, if necessary, and overall results for the committee to evaluate and review.



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Page 18 of 18

The CQI coordinator will identify and refer repetitive concerns to the Administrator for final resolution, should in-service and retraining not remedy the situation and violations.

Completion date: 3/29/13



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

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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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1962.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>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.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1962.</p> <p>GENERATOR: Type II generators installed in 1994 and 2008. Fuel source is Propane.</p> <p>A standard Life Safety Code survey was conducted on 02/20/13. Covington's Convalescent Center 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 Sixty-Seven (67) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000	<p><b>COVINGTON'S CONVALESCENT CENTER, INC.</b> 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.</p> <p><b>COVINGTON'S CONVALESCENT CENTER, INC.'S</b> 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.</p> <p><b>K 018 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>A survey of all resident rooms took place during and after the inspection to ensure a resident room doors were not blocked from closing. A rolling over bed table was repositioned in room #125, a walker and rolling over bed table were repositioned in room #227, and walkers were repositioned, near the residents that use them, in rooms #123, #127, and #226. The licensed nurses, CNAs, housekeeping staff, laundry staff, and maintenance department were all made aware that the corridor doors to the resident rooms must remain clear, and unobstructed, so that there were no impediments to the door closing. Regular weekly surveys have occurred in the facility in all the residents</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm.	(X6) DATE 4-04-13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	rooms on 02/20/13, 03/13/13, and 03/14/13 to reposition and/or remove items and, if necessary, to discuss this with the residents, if appropriate, concerning the necessity of having the doorway unobstructed.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 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  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the	K 018	Individual conferences have been conducted with facility nursing personnel, and maintenance personnel, specifically those who visit the rooms daily, and in-services on 02/21/13, 03/13/13, and on 03/14/13 have been conducted relative to maintaining unobstructed corridor doorways.  The facility has utilized a local carpenter, maintenance personnel, and a local door maintenance and installation contractor to adjust, realign, install necessary molding, and apply metal weather stripping to the corridor doors to rooms #230, #214, #210, #202, #200, #101, #104, #118 to ensure closure gaps were maintained at a minimum. This work occurred on 02/26/13, 02/27/13, and from 03/04/13 through 03/15/13.  Identify others:  All resident room corridor doors have the potential to be affected by the same practices should other resident room doors be blocked by rolling over bed tables, or by a rolling walker, or other furniture, or when doors that have a gap of more than 1/2 inch. There were no doors blocked by door stops, chocks, tie-backs, drop-down or plunger type devices, or other devices	

Page 2 of 27

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

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
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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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(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
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K 018	<p>Continued From page 2</p> <p>potential to affect two (2) of six (6) smoke compartments, ten (10) residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure five (5) resident doors could be closed with a single motion and eight (8) doors had over the allowable gap around the door jamb.</p> <p>The findings include:</p> <p>Observations, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the corridor doors to the resident rooms were blocked from closing. The rooms affected by this were rooms #125 with a table blocking door, #227 with a walker and table blocking the door, and #123, #127, and #226 with a walker blocking the door.</p> <p>Interviews, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware the items were blocking the doors from closing.</p> <p>Observations, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed corridor doors to rooms #230, #214, #210, #202, #200, #101, #104, and #118 had a gap larger than 1/2 inch around the jamb.</p> <p>Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware of the acceptable</p>	K 018	<p style="text-align: right;">Page 3 of 27</p> <p>that necessitated manual unlatching a releasing action.</p> <p><b>Systemic changes:</b></p> <p>Regular quarterly and periodic visual inspections of resident rooms will be conducted by the maintenance department and the administrative staff to ensure that the facility is following its policy to ensure that there are no impediments to the closing of resident room corridor doors and maintaining appropriate gaps in door jambs. The facility maintenance policy and procedure for inspecting resident room doors will be updated and revised to include quarterly and periodic visual inspections and perform repairs necessary to maintain compliance with the facility policy and NFPA Life Safety Code Standards relative to impediments in doorways and gaps around the door jamb.</p> <p><b>Monitoring:</b></p> <p>The Continuous Quality Improvement CQI program will include documentation, as a portion of the Life Safety Code Section of the Continuous Quality Improvement Policy and Protocol records. This will ensure that regular monthly and periodic observations and reports reflecting the adherence to the policy of the facility are maintained. These minutes will reflect quarterly and periodic compliance reviews of the facility's policy and procedure concerning impediments to door closings and the proper gap of door to door jamb.</p>	
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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 018	<p>Continued From page 3 gap around the doors.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and 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.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved</p>	K 018	<p style="text-align: right;">Page 4 of 27</p> <p>The documentation of the same will be regularly maintained within the COI minutes.</p> <p style="text-align: right;">Completion Date: 3/27/13</p> <p><b>K 025 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>On 03/14/13 and 03/15/13 a routine inspection was conducted of all smoke barriers within the facility by the maintenance staff. The object of the inspection was to locate penetrations by any pipes or wires to the smoke barrier and repair them. Generally, these penetrations were the result of independent contractors installing new equipment or repairing equipment in the facility. The smoke partition at the breezeway of the activities building next to room #116 and smoke partitions next to room #223 were inspected and repaired with a fire barrier sealant at the areas identified.</p> <p><b>Identify others:</b></p> <p>When any maintenance work is contracted to vendors outside the facility and/or when any new equipment is installed or repaired in the facility that could, in any way, create a penetration to the firewall or smoke barrier; an immediate inspection of the affected area will be conducted by the maintenance department. If indeed, smoke barrier penetrations have occurred they</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 018	Continued From page 4 automatic sprinkler system in accordance with  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	will be repaired, by the maintenance department in coordination with completion of the maintenance work or equipment installation, as soon as the work is completed,  <b>Systemic changes:</b>  The facility shall reinforce its Hazardous Materials Section policy and procedure relative to smoke barrier penetrations that have occurred during any scheduled maintenance, and/or installation or updating of equipment, where contractors have been working in areas above the ceiling. Any penetrations of the smoke barriers and/or firewalls shall be repaired as soon as the work is completed. Conferences with the contractors will be conducted to expedite the location of areas where fire-wall and/or smoke wall penetrations may have occurred.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the	K 025	<b>Monitoring:</b>  The Continued Quality Improvement, CQI, policy and protocol relative to the Hazards Section has been updated to emphasize consultation with contractors when installing and/or upgrading facility equipment. This could include, but not be limited to, the repair or upgrades, installation of telephone equipment, nurses call system repairs, fire alarm systems repairs, plumbing repairs,, and or any upgrade to present equipment and/or installation of new equipment. Regularly scheduled quarterly meetings will	

Page 5 of 27

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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K 025	<p>Continued From page 5</p> <p>potential to affect five (5) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (6) on the day of the survey. The facility failed to ensure three (3) smoke barriers were sealed around pipes and wires to resist the passage of smoke. This deficiency was cited on the previous survey on 11/16/11.</p> <p>The findings include:</p> <p>Observations, on 02/20/13 between 10:05 AM and 11:00 AM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the smoke partitions, extending above the ceiling located at the breezeway at Activities, next to room #116, and next to room #223, were penetrated by pipes and wires. Further observation revealed drywall mud and quick foam were used on a concreted block wall.</p> <p>Interview, on 02/20/13 between 10:05 AM and 11:00 AM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware of the penetrations in the smoke barriers as they have been inspected several times since the last survey. Further interview revealed they were unaware the quick foam and drywall mud were not suitable to seal a 2 hour wall.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar</p>	K 025	<p style="text-align: right;">Page 6 of 27</p> <p>document all recent repairs and upgrades or additions of equipment and the need for inspection of and repair of the smoke barrier and/or firewall within the facility to maintain the integrity of the barrier.</p> <p style="text-align: right;">Completion Date: 3/29/13</p> <p><b>K027 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>The facility has utilized a local carpenter, maintenance personnel, and a local door maintenance and installation contractor to adjust, realign, and install necessary molding to eliminate and/or minimize the gap in the corridor doors to rooms #230, #214, #210, #202, #200, #101, #104, and #118.</p> <p>The work will also ensure closure gaps were maintained at a minimum. Metal weather stripping was applied to the cross-corridor next to the administrator's office, next to room #223, and next to room #201. This work on the gaps in the cross-corridor doors occurred on 02/26/13, 02/27/13, and from 03/04/13 through 03/15/13. Christian County Door and Glass Company has examined the cross corridor doors next to room #201 for the application of a coordinating device. During the analysis testing the door, the closure devices were set in order to close the door with the astragal to coordinate and ensure proper closure of the adjacent door. The company's first</p>	
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K 025	Continued From page 6 building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.  8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025	<p style="text-align: right;">Page 7 of 27</p> <p>recommendation to solve this issue was to accomplish this by varying the closing time of the automatic closing mechanism. Nevertheless, the contract was signed for work to be done on 04/05/13.</p> <p><b>Identify others:</b></p> <p>All resident room and cross -corridor doors have the potential to be affected by the same practices should they not be maintained in an appropriate manner to ensure the appropriate gap around the door jamb. This would include routine and regular inspections to ensure closure and to monitor for the width of gap in the resident room and cross-corridor doors.</p> <p><b>Systemic changes:</b></p> <p>Regular quarterly and periodic visual inspections of the resident room and cross-corridor doors will be conducted by the maintenance department and the administrative staff to ensure that the facility is following its policy to ensure appropriate gaps in door jambs and proper closing. The facility maintenance policy and procedure for inspecting resident room doors will be updated and revised to include quarterly and periodic visual inspections and perform repairs necessary to maintain compliance with the facility policy and NFPA Life Safety Code Standards relative to the resident room and cross-corridor doors and gaps in the door.</p> <p><b>Monitoring:</b></p>	
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 027		

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K 027	<p>Continued From page 7</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure the cross corridors doors would close tight and properly.</p> <p>The findings include:</p> <p>Observation, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the cross-corridor doors located at the Administrator's office, next to room #223, and next to room #201 would not close completely when tested. The doors left a gap that was larger than 1/8 of an inch. Further observation revealed the doors located next to room #201 swung in the</p>	K 027	<p style="text-align: right;">Page 8 of 27</p> <p>The Continuous Quality Improvement CQI program will include documentation, as a portion of the Life Safety Code Section relative to door gaps and closure of the Continuous Quality Improvement Policy and Protocol records. This will ensure that regular monthly and periodic observations and reports reflecting the adherence to the policy of the facility are maintained. These minutes will reflect quarterly and periodic compliance reviews of the facility's policy and procedure concerning resident room and cross-corridor door closings and the proper gaps of the door when closed. The documentation of the same will be regularly maintained within the CQI minutes.</p> <p style="text-align: right;">Completion Date: 4/05/13</p> <p><b>K 029 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>On 03/15/13 and 03/18/13 a 1 1/2 hour fire rated door with automatic closer was installed on the dry storage area within the kitchen.</p> <p>On 02/26/13 and 02/27/13 the nursing chart room, the activity storage room, the medical records room, the Activity Director's office, and room #117 had door closers installed.</p> <p><b>Identify others:</b></p>	
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K 027	Continued From page 8 same direction and were not equipped with a door coordinating device.  Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware the doors had such a large gap and that door coordinators were required if the doors swung in the same direction and were equipped with an astragal.  Reference: NFPA 101 (2000 Edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.  Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 027	<p style="text-align: right;">Page 9 of 27</p> <p>Any doorway to a hazardous area within the facility has the potential to be affected by the same practice if it does not have the appropriate fire rated door barrier with a closing device. Since the facility has 100% automatic sprinkler protected the nurses chart room, the activity storage room, the medical records room, and the activity director's office doors may be of a lesser hourly rating than the hazardous areas.</p> <p><b>Systemic changes:</b></p> <p>The policy and procedure for routine maintenance inspection of doorways within the building will be revised and updated to include regular and routine inspections of hazardous rooms such as repair rooms, sold linen rooms, trash collection rooms, and rooms used for storage of combustible supplies to ensure that these rooms are protected by a properly maintained and working doors and closing devices.</p> <p><b>Monitoring:</b></p> <p>The Continuous Quality Improvement CQI program will include documentation in the money Safety Code Section from consultation with the maintenance department that routine and regular quarterly inspections of all hazardous room doors and closers have been conducted and records properly maintained concerning their presence and functionality.</p>	
K 029 SS=E		K 029		

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K 029	<p>Continued From page 9</p> <p>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 five (5) of six (6) smoke compartments, forty-five (45) residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure six (6) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p> <p>Observation, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the door for the dry storage room in the kitchen had been removed, the chart room had the door closer taken apart, the Activity storage room (birthday room) had no door closer</p>	K 029	<p>Page 10 of 27</p> <p>Completion date: 03/29/13</p> <p><b>K 038 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>On 03/01/13 new signs with white letters not less than 1" high and not less than 1/8" in stroke width on a red contrasting background which reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" were custom ordered from Compliance Signs. On 03/07/13 the signs were received by the facility and installed on all exit doors, as indicated.</p> <p><b>Identify others:</b></p> <p>All exit doors must be equipped with signage for the delayed egress instructions.</p> <p><b>Systemic changes:</b></p> <p>The resident safety policy and procedure will be updated to include periodic and annual inspections of delayed egress signs and doors in order to ensure the integrity of the signage. The maintenance department shall maintain inspection logs to indicate the integrity of the signs and evidence of regularly visually checking each exit door signs and inspecting them at least annually.</p> <p><b>Monitoring:</b></p>	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
NAME OF PROVIDER OR SUPPLIER  COVINGTON'S CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 029	<p>Continued From page 10</p> <p>installed, the Medical Records had no door closer installed, the Activity Director office had no door closer installed, and room #117 had no door closer installed. This requirement is due to the storage of combustible items inside the areas.</p> <p>Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware the storage in a room determined whether the room was a hazardous storage area or not.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>),</li> </ol>	K 029	<p style="text-align: right;">Page 11 of 27</p> <p>The Continuous Quality Improvement CQI program will include documentation as a portion of its Life Safety Code Section related to Hazards and Safety to ensure that regular periodic and annual records have been maintained relative to the inspections of the delayed egress signs on all exit doors.</p> <p style="text-align: right;">Completion Date: 3/29/13</p> <p><b>K 045 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>A local electrical contractor, Means and Fort Electric, Hopkinsville, Kentucky has been engaged by the facility to install the emergency lights outside the building on the sidewalk at the rear entrance of the Activity Building. These emergency lights will have at least two bulbs and provide illumination for 2 exits. The required illumination shall be arranged so that failure of any single lighting unit does not result in an illumination level of less than 0.2 foot candles in any area. An annual inspection of the emergency lighting for the facility was conducted by Vanguard Alarm Services 02/26/13 and certification stickers were applied.</p> <p><b>Identify others:</b></p> <p>To ensure a safe egress at exit doors Emergency lights must be maintained at</p>	

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

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OMB NO. 0938-0391

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K 029	Continued From page 11 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.	K 029	every exit of the facility to ensure the safety of his visitors and residents.  <b>Systemic changes:</b>  The facility has retained Vanguard Alarm Services to conduct annual emergency exit lighting inspections and certifications.  <b>Monitoring:</b>  The Continuous Quality Improvement CQI program will include documentation as a portion of his Life Safety Code Section to ensure regular annual and periodic monitoring of the performance of emergency lighting. This will ensure that the maintenance department regularly records inspections and maintains detail reports of actions that need to be taken. The documentation will be maintained within the CQI minutes.	
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 egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure all egress doors had the proper signage for delayed egress doors.	K 038	<b>K 046 NFPA 101 LIFE SAFETY CODE STANDARD</b>  <b>Corrective action:</b>  An inspection of the emergency lighting for illumination and the exit lights located at doorways for the facility was conducted by Vanguard Alarm Services on 02/26/13 and certification stickers were applied. The 30 second functional test was performed by the maintenance department on 03/13/13 of the interior and the exterior	Page 12 of 27  Completion Date: 04/05/13

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
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Page 13 of 27

K 038	<p>Continued From page 12</p> <p>The findings include:</p> <p>Observation, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed all egress doors in the facility were equipped with signage for the delayed egress doors with the lettering only being 3/4 of an inch tall.</p> <p>Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they had purchased the signs recently and were not aware of the lettering requirements on the signs.</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved,</p>	K 038	<p>emergency lighting systems and documented in the maintenance records accordingly. Records are maintained within the facility maintenance log books. The 1 1/2 hour testing of emergency lights was performed by the maintenance department on 03/15/13 and documented accordingly.</p> <p><b>Identify others:</b></p> <p>Emergency lights must be maintained and inspected utilizing functional 30 second testing monthly and 1 1/2 hour testing of emergency lights must be performed annually. Equipment must be fully operational and written records maintained by the maintenance department in the department log books.</p> <p><b>Systemic changes:</b></p> <p>The facility has retained Vanguard Alarm Services to conduct quarterly emergency lighting inspections and certifications and the maintenance department as part of its quality assurance program will continue to conduct the functional 30 second test monthly, and the 1 1/2 hourly endurance test annually. Documentation of inspections of all emergency lighting fixtures and the results will be written within the maintenance log books.</p> <p><b>Monitoring:</b></p> <p>The Continuous Quality Improvement CQI program will include documentation as a</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>COVINGTON'S CONVALESCENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>115 CAYCE ST HOPKINSVILLE, KY 42240</b>		
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K 038	Continued From page 13 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.  (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.  (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.  (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	K 038	<p style="text-align: right;">Page 14 of 27</p> <p>portion of his Life Safety Code Section to ensure regular annual and periodic monitoring of the performance of emergency exit lighting. This will ensure that the maintenance department regularly records inspections and maintains detail reports of actions that need to be taken. The documentation will be maintained within the CQI minutes.</p> <p>The facility has retained Vanguard Alarm Services to conduct annual emergency exit lighting inspections and certifications</p> <p style="text-align: right;">Completion Date: <b>04/05/13</b></p> <p><b>K 047 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>A local electrical contractor, Means and Fort Electric, Hopkinsville, Kentucky has been engaged by the facility to install the 2 additional illuminated emergency exit lights at the breezeway on the 100 and 200 hallways. The installation of the illuminated emergency exit lights connected to the generator shall be complete by 03/29/13. Exit lights other than main exit doors should be obviously and clearly identifiable as exits and shall be marked by an approved illuminated sign visible from any direction.</p> <p><b>Identify others:</b></p> <p>All exit doors other than main exits have the potential to be affected by the same</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 038	Continued From page 14 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.  (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	K 038	practice if Exit lights are not present and are not obviously and clearly identifiable as exits and are not marked by an approved illuminated sign visible from any direction.  <b>Systemic changes:</b>  The facility has retained Vanguard Alarm Services to conduct annual emergency exit and outside lighting inspections and certifications. The maintenance department, as part of its quality assurance program, will continue to conduct quarterly inspections of all interior and exterior emergency exit lighting fixtures periodically and quarterly.		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census	K 045	<b>Monitoring:</b>  The Continuous Quality Improvement CQI program will include documentation as a portion of his Life Safety Code Section to ensure regular annual, quarterly, and periodic monitoring of the performance of emergency exit lighting. This will ensure that the maintenance department regularly records inspections and maintains detail reports of actions that need to be taken. The documentation will be maintained within the CQI minutes.  The facility has retained Vanguard Alarm Services to conduct annual emergency exit lighting inspections and certifications		Page 15 of 27  Completion Date: 4/5/13

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

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Page 16 of 27

K 045	<p>Continued From page 15 of Sixty-Seven (67) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at two (2) exits.</p> <p>The findings include:</p> <p>Observation, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the exterior exits in the Activity Center did not have any lighting of the outside of the exits.</p> <p>Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path.</p> <p>Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p>	K 045	<p><b>K 052 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective Action:</b></p> <p>During the inspection of 02/20/13, when it was discovered that the quarterly fire alarm inspections contract had inadvertently not been signed and consummated after a new fire alarm system had been installed, even though a verbal commitment was initiated by the facility; an immediate fire alarm inspection was scheduled for the next day. During the inspection 02/20/13 Vanguard alarm services promptly reported to the facility on 02/21/13 and performed the fire alarm inspection and completed the inspection and testing reports. The maintenance department documented the completion of the inspection within its maintenance records.</p>	
K 046 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on interview and facility record review, it was determined the facility failed to provide</p>	K 046	<p><b>Identify others:</b></p> <p>Any quarterly inspection report that is due to be performed for the facility has the potential to be affected by the same practice if the inspection is inadvertently omitted and/or facility inspection contracts are not timely renewed.</p> <p><b>Systemic changes:</b></p> <p>The Policy and Procedure for auditing quarterly inspection reports by the maintenance department has been updated and revised to reflect regular reviews of</p>	

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

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K 046	<p>Continued From page 16</p> <p>emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure they conducted annual emergency lighting testing for the minimum requirement of Emergency lighting of at least 1-1/2 hour duration and 30 seconds monthly.</p> <p>The findings include:</p> <p>Observation and record review, on 02/20/13 at 11:09 AM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed that the emergency lights, with battery backup, located throughout the facility had not been tested for 1-1/2 hours within the last year. Further observation revealed the battery powered lights were not being checked for 30 seconds a month.</p> <p>Interview, on 02/20/13 at 11:09 AM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware the lighting had to be tested annually for 1-1/2 hours and monthly for 30 seconds.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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</p>	K 046	<p>Page 17 of 27</p> <p>the documentation of these reports by the maintenance department supervisor and to ensure that they should be scheduled and completed timely for the facility during each quarter.</p> <p><b>Monitoring:</b></p> <p>The Continuous Quality Improvement CQI program will include documentation as a portion of his Life Safety Code Section to ensure that regular quarterly fire alarm inspections have been performed and paperwork completed. Copies of these reports must be filed with the maintenance department within their maintenance manuals and also within the facility's public record. This will ensure that the maintenance department regularly records inspections and maintains detail reports of actions taken. The documentation will be maintained within the CQI minutes.</p> <p>Completion Date: 3/29/13</p> <p><b>K 056 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>02/25/13 and 02/26/13 the facility's maintenance department relocated any fixtures on the ceiling that could conceivably be considered blocking a sprinkler head and made arrangements with Pennyrile Fire Safety to subcontract work to Ohio Valley Sprinkler Company associated with changing one standard</p>	

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

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K 046	Continued From page 17 floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 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 11/2 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	response sprinkler head to a quick response sprinkler head located in one compartment behind the facility's clothes dryer. A light fixture and public address system speakers were relocated in a place to be more than 1 foot from a sprinkler head located at the 200 call nurses' station, rooms #230, #227, #226, #121, #123, #120, and at the front of the 200 hall.  <b>Identify others :</b>  Sprinklers shall be positioned in accordance with minimum distances so that they are located sufficiently away from obstructions and fixtures. When quick response sprinkler heads are installed within a compartment, this fixture must be compatible with other sprinkler heads is within that compartment.  <b>Systemic changes:</b>  The Policy and Procedure and quality assurance program will be updated and revised to reflect regular reviews of the addition of any new fixtures within the facility that might obstruct sprinkler heads. This could include any project where items would be adhered to or placed on the ceiling or wall near a sprinkler head. The addition of any new equipment and/or fixtures to the facility must be evaluated prior to installation and implementation.	
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047		

Page 18 of 27

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
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NAME OF PROVIDER OR SUPPLIER  COVINGTON'S CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 116 CAYCE ST HOPKINSVILLE, KY 42240
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K 047	<p>Continued From page 18</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure the exit paths were clearly marked.</p> <p>The findings include:</p> <p>Observation, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the exit signs located at the breezeway on 100 and 200 halls were not illuminated.</p> <p>Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were aware the exit signs in the facility were required to be illuminated.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.</p> <p>7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by</p>	K 047	<p style="text-align: right;">Page 19 of 27</p> <p>The Continuous Quality Improvement CQI program will include documentation as a portion of his Life Safety Code Section to ensure regular reviews of any new projects that would involve installation of any new fixtures or other items that could in any way involve the obstruction of the sprinkler system. Copies of these evaluations of new projects must be reviewed with the administrative staff and with the maintenance department prior to implementation. The documentation of these reviews will be maintained within the CQI minutes.</p> <p style="text-align: right;">Completion Date: 3/29/13</p> <p><b>K 062 NAPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>The Ohio Valley Sprinkler Company performed an inspection of the interior portion of the pipe within the sprinkler system of the facility on 3/14/13.</p> <p><b>Identify others:</b></p> <p>The facility must ensure that the interior of the sprinkler pipe in the sprinkler system has been inspected within five-year intervals.</p> <p><b>Systemic changes:</b></p> <p>The Policy and Procedure and quality assurance program will be updated and revised to reflect regular reviews of the</p>	
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K 047	Continued From page 19 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.	K 047	performance of the inspection of the interior of the pipe with the sprinkler system. The maintenance department will maintain records to ensure that mandatory testing be performed at the required intervals and document the same.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection review, the facility failed to test the fire alarm system quarterly per NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure the fire alarm for the facility had been tested	K 052	<p>Page 20 of 27</p> <p>Monitoring:</p> <p>The Continuous Quality Improvement CQI program will include documentation as a portion of his Life Safety Code Section to ensure regular reviews of maintenance records to reflect regular inspections of the interior pipe of the sprinkler system. These inspections shall be performed at the required intervals. Copies of these inspections must be reviewed with the administrative staff and with the maintenance department. The documentation of these reviews will be maintained within the CQI minutes.</p> <p>Completion Date: 3/6/13</p> <p>K 069 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Corrective action:</p> <p>On 03/08/13, Pennyriple Fire Safety performed the range hood system inspection. The hydrostatic test involved testing of the Agent cylinders, valve assemblies, all safety valves and/or seals. These were properly installed and the system was recharged with the necessary fire retardant.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 052	Continued From page 20 quarterly.  Findings include:  Fire alarm inspection review, on 02/20/13 at 1:47 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the facility failed to provide documentation to show the fire alarm had been tested since June of 2011.  Interview, on 02/20/13 at 1:47 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the facility had installed a new fire panel at that time and wanted to switch the testing to the company that installed the panel. The contract had not been finalized so the new panel was not inspected since installation.  Reference: NFPA 101 (2000 ed.)  9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052	<b>Identify others:</b>  The facility must ensure that the extinguishing agent for the kitchen range hood suppression system is hydrostatically tested and recharged during the required intervals. Pennyrile Fire Safety must complete the test timely and document the testing on the appropriate tags to simplify monitoring. The hydrostatic test on dry chemical, stored pressure, with mild steel shells must be performed every 12 years and conspicuously dated as such.  <b>Systemic changes:</b>  The Policy and Procedure and quality assurance program will be updated and revised to reflect regular reviews of the performance of the hydrostatic test and recharging on the kitchen range hood suppression system. The maintenance department will maintain records to ensure that mandatory testing be performed at the required intervals and the appropriate documentation is maintained and dated on the cylinders.  <b>Monitoring:</b>  The Continuous Quality Improvement CQI program will include documentation as a portion of his Life Safety Code Section to ensure regular reviews of maintenance records to reflect regular reviews of the documentation for hydrostatic testing dates. These inspections shall be		
K 056 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  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	K 056			

Page 21 of 27

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

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K 056	<p>Continued From page 21</p> <p>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 observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, fifty-three (53) residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure nine (9) sprinkler heads were not blocked by fixtures on the ceiling and that all sprinkler heads matched in a compartment.</p> <p>The findings include:</p> <p>Observations, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the sprinkler heads located at the 200 hall nurses' station, rooms #230, #227, #226, #121, #123, #120, and a sprinkler at the front of 200 hall in the corridor were blocked by light fixtures and speakers, within 1 foot of the sprinkler head, extending below the sprinkler heads.</p> <p>Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel,</p>	K 056	<p>Page 22 of 27</p> <p>performed at the required intervals. Copies of these inspections must be reviewed with the administrative staff and with the maintenance department. The documentation of these reviews will be maintained within the CQI minutes.</p> <p>Completion Date: 3/29/13</p> <p><b>K 144 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective action:</b></p> <p>The transfer time for the generator shall be documented by the facility maintenance department within the maintenance records. Bids have been secured from Vanguard Generator Service, Evansville Indiana that proposes alternative methods to eliminate a delay of more than 10 seconds for the maintenance of illumination within the facility.</p> <ol style="list-style-type: none"> <li>Vanguard proposes to install a new generator and transfer switches for a system to replace the existing two generators. Model IGLC 50 KW with digital control panel, sound attenuated enclosure, block heater, 10 amp battery charger, lamp annunciator and remote emergency stops, 2 125 amp transfer switches. The system includes the following options: Test switch, manual bypass of transfer to normal time delay, ATS positioning lights, source of available lights, engine test with load/no loads switch, in</li> </ol>	
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K 056	<p>Continued From page 22</p> <p>revealed they were unaware that the light fixtures could block the spray pattern of the sprinkler head.</p> <p>Observations, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed a standard response sprinkler head and quick response sprinkler head in the same compartment located in the area behind the dryers.</p> <p>Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were not aware that the sprinklers had to have the same engagement heat if the sprinkler heads are located in the same compartment.</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 style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Maximum Allowable Distance</td> <td></td> </tr> <tr> <td style="text-align: center;">Distance from Sprinklers to</td> <td style="text-align: center;">of Deflector</td> </tr> <tr> <td style="text-align: center;">above Bottom of</td> <td></td> </tr> <tr> <td style="text-align: center;">Side of Obstruction (A)</td> <td style="text-align: center;">Obstruction (in.)</td> </tr> <tr> <td style="text-align: center;">(B)</td> <td></td> </tr> </table>	Maximum Allowable Distance		Distance from Sprinklers to	of Deflector	above Bottom of		Side of Obstruction (A)	Obstruction (in.)	(B)		K 056	<p style="text-align: right;">Page 23 of 27</p> <p>phase monitor, and load disconnect contacts.</p> <p>2. Vanguard also prepared a proposal to install a new generator and transfer switch that will power the entire building according to the service size and current electrical draws. Model ILDC 200, 200 KW 120/240 single phase, 24 hour sub base tank, digital control panel, solid attenuated enclosure, muffler, block heater, 10 amp battery charger, 1000 amp main circuit breaker, NFPA 110 kit, 15 amp annunciator and remote emergency stop switch 1200 amp transfer switch.</p> <p>Currently, the administrator is contacting Hopkinsville Electric Service in order to ascertain records revealing the kilowatt usage and peak kw usage during the past two years to check compatibility with the proposed generators. TVA has also been contacted to perform a feasibility study that will support the use of a new generator and coordinate the actual generator size needed. Consultation with local electrical contractors, Means &amp; Fort Electric is ongoing to ensure compatibility of the new systems with the electrical service now utilized.</p> <p>It seems prudent to definitively examine, investigate, and evaluate a new generator system installation due to the adoption of new 2012 NFPA inspection codes that will be used for our next inspection and the</p>	
Maximum Allowable Distance														
Distance from Sprinklers to	of Deflector													
above Bottom of														
Side of Obstruction (A)	Obstruction (in.)													
(B)														

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K 056	Continued From page 23 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  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	K 056	<p style="text-align: right;">Page 24 of 27</p> <p>huge installation cost to replace two perfectly good generators, that in and of themselves, start and operate in less than 10 seconds. The only delay is within the transfer relay mechanisms that ensure total disconnect from electricity prior to finalizing a new power source. Due to the short time frame given to make an informed decision, and without being given enough time to properly obtain all the necessary assurances from the local utility and TVA of compatibility of the new generator with the current service size and current peak electrical draws, the planned feasibility studies are a foregone conclusion, leaving little or no option, but to sign the contract with Vanguard Generator Service to order and install a new 200kw generator, per the proposal listed above. Since new generators are built to order, the proposed delivery and installation is projected for 10-12 weeks from the date of contract. The contract with Vanguard Generator Service was signed to initiate the order on 04/04/13.</p> <p><b>Identify others:</b></p> <p>Maintenance of illumination depends connecting from one energy source to another, a delay of not more than 10 seconds shall be permitted. Even though current generators start immediately when power is called for, there are certain delays with the transfers relays and mechanisms to control absolute cut off from electric service before generator service is initiated. Strict coordination of the</p>	
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K 056	Continued From page 24 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 sprinklers shall be permitted to be used.	K 056	transfer mechanisms is paramount for safety of the entire electrical system.  <b>Systemic changes:</b>  The Policy and Procedure and quality assurance program for the Life Safety Code Section will be updated and revised to reflect regular documentation of the transfer time of the generator at the facility. The maintenance department shall maintain records reflecting accurate readings of the transfer times.	
K 062 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  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  This STANDARD is not met as evidenced by: Based on observation, record review, 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 six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure the interior of the pipe in the sprinkler system was inspected within the past five (5) years.  The findings Include:  Observation and record review, on 02/20/13 at 1:55 PM with the Maintenance Supervisor,	K 062	<b>K 147 NFPA 101 LIFE SAFETY CODE STANDARD</b>  <b>Corrective action:</b>  The Continuous Quality Improvement CQI program will include documentation as a portion of his Life Safety Code Section to ensure regular recording in maintenance records to reflect regular documentation of the transfer time for the generator. The quarterly CQI meetings will be conducted by the Asst. Administrator and/or the Adm. Assistant RN, and will include any issues discovered during observation of the maintenance department documentation and evaluations, needed corrections, and overall results for the committee to evaluate and review.  Completion Date: <i>4/04/13</i>	

Page 25 of 27

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

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FORM APPROVED  
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K 062	<p>Continued From page 25</p> <p>Resident Services, and Maintenance personnel, revealed the facility failed to provide documentation that the interior of the sprinkler piping had been inspected within the last 5 years. The inspection company checked back to 2006 and could not find any record of the service. Further record review revealed the sprinkler company had recommended an obstruction investigation on the last three quarterly inspection reports.</p> <p>Interview, on 02/20/13 at 1:55 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware the work had not been completed. They were under the impression the note on the report was a suggestion and did not know it was required by the NFPA.</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems)</p>	K 062	<p>Storage cabinets in the dry storage area of the kitchen, the laundry storage closet, the rear hall electrical room, the activity furnace room, and the maintenance office were either moved to the storage building or rearranged in the existing storage areas to ensure that there was a 3 foot clearance between the cabinets in the electrical panels on 02/28/13 and 03/18/13.</p> <p>The power strips that were mounted to the walls in resident rooms of the facility were removed from the rooms on 02/21/13 and 02/22/13. Three power strips that were daisy chained to one another in the administrator's office were removed and other satisfactory electrical connections provided on 03/04/13.</p> <p>The two air mattresses plugged into a power strip in rooms #222 and #211 were disconnected and the mattresses plugged into other outlets on 02/22/13.</p> <p><b>Identify others:</b></p> <p>Sufficient access and working space shall be provided and maintained near all electrical equipment panels to permit safe operation and maintenance. Electrical strips must not be mounted to walls for permanent wiring in resident rooms of the facility nor should the power strips be used for medical equipment. Daisy chain of power strips in not permitted in facility offices.</p> <p><b>Systemic changes:</b></p>	

Page 26 of 27

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
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K 062	<p>Continued From page 26</p> <p>Inspection Weekly/monthly 2-2.4.2</p> <p>Control valves Inspection Weekly/monthly Table 9-1</p> <p>Alarm devices Inspection Quarterly 2-2.6</p> <p>Gauges (wet pipe systems) Inspection Monthly 2-2.4.1</p> <p>Hydraulic nameplate Inspection Quarterly 2-2.7</p> <p>Buildings Inspection Annually (prior to freezing weather)</p> <p>2-2.5</p> <p>Hanger/seismic bracing Inspection Annually 2-2.3</p> <p>Pipe and fittings Inspection Annually 2-2.2</p> <p>Sprinklers Inspection Annually 2-2.1.1</p> <p>Spare sprinklers Inspection Annually 2-2.1.3</p> <p>Fire department connections Inspection Table 9-1</p> <p>Valves (all types) Inspection Table 9-1</p> <p>Alarm devices Test Quarterly 2-3.3</p> <p>Main drain Test Annually Table 9-1</p> <p>Antifreeze solution Test Annually 2-3.4</p> <p>Gauges Test 5 years 2-3.2</p> <p>Sprinklers - extra-high temp. Test 5 years 2-3.1.1</p> <p>Exception No. 3</p> <p>Sprinklers - fast response Test At 20 years and every 10 years thereafter</p> <p>2-3.1.1 Exception No. 2</p> <p>Sprinklers Test At 50 years and every 10 years thereafter</p> <p>2-3.1.1</p> <p>Valves (all types) Maintenance Annually or as needed Table 9-1</p> <p>Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 062	<p style="text-align: right;">Page 27 of 27</p> <p>The Policy and Procedure and quality assurance program for the Life Safety Code Section will be updated and revised to reflect that power strips may not be mounted to the walls in resident rooms nor in any other room within the facility. The maintenance department shall maintain records reflecting periodic and quarterly inspections of resident rooms and facility offices to ensure appropriate use of power strips.</p> <p><b>Monitoring:</b></p> <p>The Continuous Quality Improvement CQI program will include documentation in the portion of the Life Safety Code Section to ensure periodic and quarterly reviews to ensure that power strips may not be mounted to the walls in resident rooms nor any other room within the facility. Nor will power strips be daisy chained to one another for any reason for use within the facility. The CQI minutes will reflect quarterly reviews, visual inspections, and documentation to ensure the policies relative to these issues are followed.</p> <p style="text-align: right;">Completion Date: 3/29/13</p>	
K 069 SS=F		K 069		

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

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K 069	<p>Continued From page 27</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain the installation of the kitchen hood suppression system in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure the kitchen hood suppression system had been hydrostatically tested since 1999.</p> <p>Findings include:</p> <p>Record review, on 02/20/13 at 2:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the extinguishing agent for the kitchen hood suppression system had not been hydrostatically tested since 1999.</p> <p>Interview, on 02/20/13 at 2:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware the kitchen hood had not been maintained properly.</p> <p>Reference: NFPA 10 (1998 ed.) 5-2 Frequency. At intervals not exceeding those specified in Table 5-2, fire extinguishers shall be hydrostatically retested. The hydrostatic retest shall be</p>	K 069		

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

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FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>COVINGTON'S CONVALESCENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>115 CAYCE ST HOPKINSVILLE, KY 42240</b>
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K 069	<p>Continued From page 28</p> <p>conducted within the calendar year of the specified test interval. In no case shall an extinguisher be recharged if it is beyond its specified retest date. (For nonrechargeable fire extinguishers, see the exception to 4-4.3.</p> <p>Table 5-2 Hydrostatic Test Interval for Extinguishers</p> <table border="0"> <tr> <td>Extinguisher Type</td> <td>Test Interval(Years)</td> <td></td> </tr> <tr> <td>Stored-pressure water, loaded stream, and/or antifreeze</td> <td>5</td> <td></td> </tr> <tr> <td>Wetting agent</td> <td>5</td> <td></td> </tr> <tr> <td>AFFF (aqueous film-forming foam)</td> <td>5</td> <td></td> </tr> <tr> <td>FFFP (film-forming fluoroprotein foam)</td> <td>5</td> <td></td> </tr> <tr> <td>Dry chemical with stainless steel shells</td> <td>5</td> <td></td> </tr> <tr> <td>Carbon dioxide</td> <td>5</td> <td></td> </tr> <tr> <td>Wet chemical</td> <td>5</td> <td></td> </tr> <tr> <td>Dry chemical, stored-pressure, with mild steel shells, brazed brass shells, or aluminum shells</td> <td>12</td> <td></td> </tr> <tr> <td>Dry chemical, cartridge- or cylinder-operated, with mild steel shells</td> <td>12</td> <td></td> </tr> <tr> <td>Halogenated agents</td> <td>12</td> <td></td> </tr> <tr> <td>Dry powder, stored-pressure, cartridge- or cylinder operated, with mild steel shells</td> <td>12</td> <td></td> </tr> </table>	Extinguisher Type	Test Interval(Years)		Stored-pressure water, loaded stream, and/or antifreeze	5		Wetting agent	5		AFFF (aqueous film-forming foam)	5		FFFP (film-forming fluoroprotein foam)	5		Dry chemical with stainless steel shells	5		Carbon dioxide	5		Wet chemical	5		Dry chemical, stored-pressure, with mild steel shells, brazed brass shells, or aluminum shells	12		Dry chemical, cartridge- or cylinder-operated, with mild steel shells	12		Halogenated agents	12		Dry powder, stored-pressure, cartridge- or cylinder operated, with mild steel shells	12		K 069		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 069	Continued From page 29	K 069		
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure the generator would transfer to the facility within ten (10) seconds.</p> <p>The findings include:</p> <p>Record review, on 02/20/13 at 11:05 AM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the transfer time for the generator was not being documented at the facility.</p> <p>Interview, on 02/20/13 at 11:05 AM with the</p>	K 144		

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

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K 144	Continued From page 30 Maintenance Supervisor, revealed he documented the time in his head and it usually takes anywhere from 15 to 20 seconds to transfer.  Reference: NFPA 101 ( 2000 ed.) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted.	K 144		
K 147 SS=F	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 six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Seven (67) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them and power strips were being used properly. Furthermore the facility was cited this deficiency previously on 11/16/11 regarding power strips.  The findings include:  Observations, on 02/20/13 between 11:00 AM	K 147		

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
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K 147	<p>Continued From page 31</p> <p>and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed the electrical panels in the dry storage area of the kitchen, the laundry storage closet, rear hall electrical room, the activity furnace room, and the maintenance office had storage within three (3) feet of the panels.</p> <p>Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were unaware that there could be any storage within three (3) feet of an electrical panel</p> <p>Observations, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed power strips mounted to the walls to be used as permanent wiring in the resident rooms of the facility. Further observation revealed an air mattress plugged into a power strip located in room #222 and #211 and three power strips daisy chained to one another in the Administrator office.</p> <p>Interview, on 02/20/13 between 11:00 AM and 5:00 PM with the Maintenance Supervisor, Resident Services, and Maintenance personnel, revealed they were under the impression they could mount the power strips to the wall to avoid there being a trip hazard for the residents.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 99 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be</p>	K 147		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 147	Continued From page 32 provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Table 110.26(A)(1) Working Spaces  Nominal Voltage to Ground      Minimum Clear Distance Condition 1      Condition 2      Condition 3 0-150      900 mm (3 ft)      900 mm (3 ft)      900 mm (3 ft) 151-600      900 mm (3 ft)      1 m (3½ ft) 1.2 m (4 ft) Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and	K 147		

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

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FORM APPROVED  
OMB NO. 0938-0391

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K 147	<p>Continued From page 33</p> <p>grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded.</p> <p>Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.</p> <p>(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.</p> <p>(c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation.</p> <p>(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.</p>	K 147			

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

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OMB NO. 0938-0391

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K 147	Continued From page 34 (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the	K 147			

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

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FORM APPROVED  
OMB NO. 0938-0391

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K 147	<p>Continued From page 35</p> <p>working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition.</p> <p>(D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D 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 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted</p> <p>Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure</li> <li>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or</li> </ol>	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:  185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  02/20/2013
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 147	Continued From page 36 floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147			