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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	185343		R 05/08/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An on-site Revisit Survey was conducted on 05/07/14-05/08/14 and it was determined the facility was in compliance on 04/24/14, as alleged in the acceptable POC.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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RECEIVED APR 2014 INSPECTOR GENERAL

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F 000	INITIAL COMMENTS A Standard Recertification Survey was conducted on 03/12/14 through 03/14/14 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 "D".	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 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 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, interview, record review and review of the facility's policy and procedures it was determined the facility failed to revise the care plan for one (1) of fifteen (15) sampled	F 280	**COVINGTON'S CONVALESCENT CENTER, INC.'S** response to the statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is totally accurate. **F 280 483.20(d)(3). 483.10(K)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE C;** **Corrective Action:** On the day of the survey 03/14/14 following a facility investigation of the incident and the establishment of the root cause of the fall, resident #7's care plan was reviewed and revised by the MDS coordinator to include a new intervention and to continue use of the previous alarms. The new intervention added to the care plan was to place Dycem, a slip resistant material to the seat of the g-chair, to help prevent the resident from sliding from the chair and to place a cushion mat on the floor in front of the g-chair to prevent injury, should a fall reoccur.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Adm.	4-24-14

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 280	Continued From page 1 residents (Resident #7). Resident #7 had an unwitnessed fall from a geri-chair and the facility failed to revise the care plan to address the root cause of the fall. The findings include: Review of the facility's policy and procedure titled, "Resident Fall and Injury Monitoring Policy-Protocol", not dated, revealed when a resident falls, the incident is evaluated thoroughly to determine any areas of risk that are amendable to modification. After determining the risk of falling the resident is educated about activities that require modification. The plan of action is determined using resident input and the care needs sheet is changed to reflect the plan of care and the new plan of care is communicated to staff. Record review revealed the facility admitted Resident #7 on 10/07/13 with diagnoses which included Depression, Sundowners, Cerebral Vascular Accident with right sided Hemiplegia, Arthritis, Vascular Dementia with Hallucinations and Insomnia. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/14/14, revealed the facility assessed Resident 7's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of ten (10) and requiring total assistance with all areas of Activities of Daily Living (ADLs). Review of the Nurse's Note, dated 01/03/14 at 4:30 PM, and an Incident Report Investigation, dated 01/03/14, revealed Resident #7 was found lying on the floor in his/her room beside his/her geri-chair. The resident stated he/she slid out of the chair. There was a note that the resident had	F 280	Page 2 of 20 Review of resident care plans occur every 90 days and as needed due to changes in resident status and will include the revision of the care plan following a fall or other incident involving resident safety and will include the addition of a new intervention that was initiated when a fall occurs, depending upon the root cause. A review of resident #7's care plan on 3/14/14 per MDS nurse revealed that bed and chair alarms were identified as an intervention previously and will be continued. In-services were co nducted on 03/31/14, 04/01/14, 04/02/14, 04/03/14, 04/04/14, 04/05/14, and 04/06/14 by the DON with Licensed Nurses on comprehensive completion of the fall assessment form to include establishing the root cause of the incident and implementing a new intervention to prevent a recurring fall, depending upon the root cause, and if appropriate. A list of the commonly used interventions to prevent a recurrence of a fall will be posted in the nurses charting room to assist nursing staff in selection of another intervention, should a change be appropriate following a fall. The nursing staff will be in-serviced on the use of the list to assist in completing the fall assessment record. **Identify Others:** All residents identified as having a fall have the potential to be affected by the same practice, if the root cause of the	

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F 280	Continued From page 2 been known for deliberately sliding out of the chair in the past. The resident was placed back in the geri-chair and then to bed. There was no documented evidence the facility determined the cause of the fall. Interview with Licensed Practical Nurse (LPN) #3, on 03/13/14 at 4:15 PM, revealed he/she had been the nurse on duty on 01/03/14 when Resident #7 fell. LPN #3 stated she assessed Resident #7 for injuries, placed him/her back in the geri-chair, then placed him/her in bed. LPN #3 revealed she did not investigate to determine the root cause of the fall and failed to revise the care plan with a new intervention to address the fall. LPN #3 revealed she should have revised the care plan. The LPN revealed Resident #7 was placed back in the geri-chair the next day (01/04/14) with no new interventions in place. Review of Resident #7's Comprehensive Care Plan for Risk for Falls, dated 10/22/13, revealed there was no revision to the care plan to address the resident sliding out of the geri-chair on 01/02/14. Further review of an Incident Report Investigation, dated 01/12/14, revealed Resident #7 had another un-witnessed fall from the geri-chair. The facility determined the cause of the fall was the sheet in the resident's geri-chair. They changed the sheet to a blanket to try to prevent a reoccurrence. Interview with the Director of Nursing (DON), on 03/13/14 at 3:20 PM, revealed the root cause of Resident #7's fall on 01/03/14 was determined to be a purposeful fall and it would have been the responsibility of the nurse working at the time of	F 280	Page 3 of 20 incident is not established and a new intervention implemented, if appropriate, depending upon the root cause. The care plan must be communicated to the nursing staff and care provided in accordance with the care plan as revised. The facility DON evaluated\screened all residents in facility utilizing a geri-chair for fall intervention. Completed on 4/4/14. No other residents were identified to have immediate concerns however Physical Therapy has completed an evaluation on Res #7 to assess risks versus benefits of geri-chair use. Res #7 was deemed appropriate for geri-chair use. MDS nurse has reviewed all care plans on 4/7/14 for careplan accuracy involving falls, type of chair specific to each resident's needs and alarms. No deficiencies noted during these reviews by the MDS nurse on 4/7/14. In addition, the MDS nurse, Administrative RN, and QA nurse have reviewed 75% of resident charts and care plans for any issue related to care planning the resident's needs as a way to ensure no care- planning deficiencies. These chart audits were completed between 4/6/14-4/23/14. QA meetings are held daily (mon-fri) with DON, MDS nurse, QA nurse, and nursing staff on duty to discuss any falls that have occurred, nature of event, root cause of fall, any new interventions, care-planning, and if therapy evaluation is needed. These daily meetings will help to ensure that all	

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F 280	Continued From page 3 the fall to have placed new interventions and to have updated the care plan.	F 280	 resident care-planning updates are completed appropriately and timely. These meetings also address resident status changes or concerns so that nursing and MDS nurse can ensure timeliness of care-planning updates.	
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, staff and resident interview, and facility policy review it was determined the facility failed to ensure interventions were implemented per the plan of care for one (1) of fifteen (15) sampled residents (Resident #2). Resident #2 was care planned to have a pressure alarm to his/her chair. However, observation of Resident #2 revealed the resident was sitting in the bedside recliner and no chair alarm was in place. The findings include: Review of the facility's policy titled, "Care Plan Policy", not dated, revealed an individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The facility's care planning/interdisciplinary team, in coordination with the resident, his/her family or representatives (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the	F 282	**Systemic Changes:** In-services were conducted on 03/31/14, 04/01/14, 04/02/14, 04/03/14, 04/04/14, 04/05/14, and 04/06/14 by the DON with Licensed Nurses on comprehensive completion of the fall assessment form to include establishing the root cause of the incident and implementing a new intervention to prevent a recurring fall, depending upon the root cause, and if appropriate. A list of the commonly used interventions to prevent a recurrence of a fall was posted in the nurses charting room on 3.31.14 by the DON to assist nursing staff in selection of another intervention, should a change be appropriate following a fall. The nursing staff were in-serviced by the DON on 03/31/14, 04/01/14, 04/02/14, 04/03/14, 04/04/14, 04/05/14, and 04/06/14 on the use of the list to assist in completing the fall assessment record. QA meetings are held daily (mon-fri) with DON, MDS nurse, QA nurse, and nursing staff on duty to discuss any falls that have occurred, nature of event, root cause of fall, any new interventions, care-planning, and if therapy evaluation is needed. These	

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F 282	Continued From page 4 resident may be expected to attain. Each resident's comprehensive care plan has been designed to incorporate identified problem areas; incorporate risk factors associated with identified problems; and, aid in preventing or reducing declines in the resident's functional status and/or functional levels. Record review revealed the facility admitted Resident #2 on 07/01/08 with diagnoses which included Mild Dementia, Mild Micro Albuminea, Cellulitis, Respiratory Distress, and Congestive Heart Failure. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 02/20/14, revealed the facility assessed Resident #2's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of a twelve (12), (which indicated the resident was not cognitively impaired) and requiring extensive assistance with Activities of Daily Living. Review of the Comprehensive Care Plan for Risk for Falls and Injury, last revised 02/21/14, revealed interventions for staff to use a pressure pad alarm for bed/chair and to answer promptly if sounds. Review of Quick Reference Card for Nurse Aides (NA), with no date, revealed Resident #2 required a pressure alarm pad for bed/chair due to fall risk. Observation, on 03/13/14 at 9:15 AM, revealed Resident #2 was sitting in a recliner and Nurse Aide (NA) #1 and NA #2 transferred Resident #2 from the recliner to the bedside commode. There was no pressure alarm on the seat of the recliner. Interviews, on 03/13/14 at 9:15 AM with NA #1 and NA #2, revealed there was no chair alarm on the recliner. NA #1 and NA #2 stated there	F 282	Page 5 of 20 daily meetings will help to ensure that all careplanning updates are completed appropriately and timely. These meetings also address resident status changes or concerns so that nursing and MDS nurse can ensure timeliness of care-planning updates. Education completed by Administrative RN on 4/7/14 for the DON and MDS nurse to ensure understanding how this will be tracked through QA. The policy and procedure for updating and reviewing of care plans following a fall for a facility resident was revised and modified by the DON and Administrator on 3/31/14 to include the following: 1. The post-fall assessment was revised to include establishing the root cause of the fall by the investigating nurse, 2. The post fall assessment was revised on 03/31/14 by the Administrator and DON to include the documentation of the new intervention implemented, depending upon the established root cause. 3. QA monitoring list was revised on 04/03/2014 to include checking the application of chair alarms to chairs, g-chairs and/or recliners, as appropriate. The QA nurse will monitor items on the quality control list weekly and as necessary. 4. Alarm monitoring for use and proper placement was added to	

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F 282	Continued From page 5 should have been a pressure alarm on the recliner per the care plan. Interview, on 03/13/14 at 10:00 AM with Certified Nursing Assistant (CNA) #7, revealed she helped transfer Resident #2 to the recliner that morning and did not recall an alarm being in the recliner. She stated Resident #2 was care planned for a pressure alarm and it should have been in place. Interview, on 03/13/14 at 9:18 AM with Licensed Practical Nurse (LPN) #1, revealed Resident #2 did not have an alarm in his/her recliner and should have had one on the recliner before staff assisted the resident to the recliner. She stated the chair alarm was included on the care plan. Interview, on 03/14/14 at 11:50 AM with Registered Nurse (RN)/Floor Supervisor #1, revealed she expected staff to be familiar with the care plan interventions and the alarm should have been in place and activated. Interview, on 03/14/14 at 10:16 AM with the Director of Nursing (DON), revealed the staff should have followed the care plan and the alarm should have been on the recliner.	F 282	Page 6 of 20 the MAR's by the QA nurse on 4.3.14 for a visual check off on each nursing shift, 7-3, 3-11, 11-7, by the facility nursing staff. **Monitoring:** The assistant administrator will continue to maintain record reviews of QA documentation that will include reviews of post fall assessments to ensure that the root cause of a fall and intervention was established at the time of the fall and that a new intervention to prevent reoccurrence of a fall was implemented, if appropriate. The CQI committee will audit/review QA reports relative to chair alarms being properly applied to g-chairs/chairs/recliners, as appropriate. These audits conducted by the CQI committee will be performed quarterly and identify any deficient practice of applying chair/g-chairs/recliners will be reported to the Administrative Staff. The Administrative Staff composed of the Asst. Adm, Adm. Asst., MDS coordinator, and/or the Compliance officer will ensure that re-training and increased comprehension is attained by the nursing staff involved. The QA nurse will continue to meet quarterly with the QA committee to discuss portions of the weekly observations of application of the chair /g-chair/recliner alarms and the need for increased emphasis on training and/or retraining in these areas to ensure	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide adequate supervision and assistive devices to prevent accidents for two (2) of fifteen (15) sampled residents (Resident #2 and Resident #7). Resident #7 slid from the geri-chair to the floor on 01/03/14 and the facility failed to determine the root cause of the fall, assess to determine if the geri-chair was safe for the resident, and revise the care plan with an intervention to try to prevent further falls. Resident #7 slid from the geri-chair again on 01/12/14. Resident #2 was care planned for a pressure alarm to chair and observation revealed Resident #2 was up in the recliner with no pressure alarm in place. The findings include: Review of the facility's policy and procedure titled, "Resident Fall and Injury Monitoring Policy-Protocol", not dated, revealed when a resident falls, the incident is evaluated thoroughly to determine any areas of risk that are amendable to modification. After determining the risk of the fall, the resident is educated about activities that require modification. The plan of action is determined using resident input and the care needs sheet is changed to reflect the plan of care and the new plan of care is communicated to staff. Record review revealed the facility admitted Resident #7 on 10/07/13 with diagnoses which included Depression, Sundowners, Cerebral	F 323	Page 7 of 20 compliance with the policy and procedure for chair/bed/recliner alarm use. MDS nurse and\or QA nurse will monitor 10% of resident census monthly x 3 months to ensure that new orders, resident condition changes, and\or care-planning needs have been updated AND carried out appropriately and timely. This 3 month period started 4/1/14. These reviews will ensure that care-planned issues are effective and carried out appropriately. QA nurse\team will review these monthly during the 90 day period as the audits are conducted to ensure follow through. Completed: **F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **Corrective Action:** Res #2's alarm was replaced by nursing staff on 3/13/14 when it was noted as being omitted during survey. On the day of the survey 03/14/14 following a facility investigation of the incident involving resident #2 to establish why the alarm was not in the proper position and functioning. Resident #2's care plan was reviewed and included an	4-24-14

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F 323	Continued From page 7 Vascular Accident with right sided Hemiplegia, Arthritis, Vascular Dementia with Hallucinations and Insomnia. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/14/14, revealed the facility assessed Resident 7's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of ten (10) and requiring total assistance with all areas of Activities of Daily Living (ADL's). Review of Resident #7's Comprehensive Care Plan for Risk for Falls due to impaired sit to stand balance, confusion, and history of making self slide to floor for attention, dated 10/22/13, revealed there were no interventions in place to address the resident falling out of the geri-chair. Review of the Nurse's Note, dated 01/03/14 at 4:30 PM, revealed Resident #7 was noted lying on the floor in his/her room beside his/her geri-chair. When the nurse asked the resident what happened, the resident stated, "I slid out of my chair". The resident was placed back in the geri-chair and then to bed. Review of an Incident Report Investigation, dated 01/03/14, revealed Resident #7 had an un-witnessed fall from a geri-chair with no injury. The resident revealed he/she had slid out of the chair. Documentation revealed "the resident had been known for doing this in the past". There was no documentation of what was determined to be the root cause of the fall and no documentation that any new interventions were put in place. Interview with Licensed Practical Nurse (LPN) #3,	F 323	Page 8 of 20 intervention on 02/12/14, pressure pad alarm to bed/chair, answer promptly, if sounds. The intervention was identified 3/14/14 by MDS nurse to state that the alarm was to be placed in the chair/recliner, to ensure that the use of the alarm pad in chair was understood to mean chair/recliner, or other types of chairs. **Identify Others:** All residents identified with the need for a special care device, such as, a bed/chair alarm have the potential to be affected by the same practice if the care plan does not specify that a chair means, recliner/g-chair/or other types of chairs, The resident care will be communicated to the nursing staff and provided in accordance with the care plan. The facility DON evaluated\screened all residents in facility utilizing a geri-chair for fall intervention. Completed on 4/4/14. No other residents were identified to have immediate concerns however Physical Therapy has completed an evaluation on Res #7 to assess risks versus benefits of geri-chair use. Res#7 was deemed appropriate for geri-chair use. MDS nurse has reviewed all care plans on 4/7/14 for care-plan accuracy involving falls, type of chair specific to each resident's needs and alarms. No deficiencies noted during these reviews by the MDS nurse on 4/7/14.	

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F 323	Continued From page 8 on 03/13/14 at 4:15 PM, revealed he/she had been the nurse on duty on 01/03/14 when Resident #7 fell. LPN #3 stated she assessed Resident #7 for injuries, placed him/her back in the geri-chair, then placed him/her in bed. LPN #3 revealed she did not investigate to determine the root cause of the fall; reassess the resident to determine if the geri-chair was safe for the resident; and, did not put in place any interventions to try to prevent further falls. LPN #3 revealed she should have and that is what he/she would have usually done. The LPN revealed Resident #7 was placed back in the geri-chair the next day (01/04/14) with no new interventions in place. Further record review revealed there was no documented evidence the root cause of the fall was determined; the resident was assessed to determine if the geri-chair was safe for the resident, and any interventions were put in place to try to prevent further falls. Review of an Incident Report Investigation, dated 01/12/14, revealed Resident #7 had an un-witnessed fall from the geri-chair again. Resident #7 stated he/she was moving around in the geri-chair, slid out of the geri-chair on to the floor and hit his/her head. She was found by the nurse on duty lying on his/her back on the floor. A blanket was placed on the geri-chair instead of a sheet to prevent reoccurrence. Interview with the Director of Nursing (DON), on 03/13/14 at 3:20 PM, revealed the root cause of Resident #7's fall on 01/03/14 was determined to be a purposeful fall and it would have been the responsibility of the nurse working at the time of the fall to have placed new interventions and to have updated the care plan. The DON further	F 323	 MDS nurse has reviewed the caretracker documentation system, quick reference cards, and nursing careplans of residents with falls\alarms to ensure all residents with alarms were noted appropriately. This audit was completed 3/18/14. QA meetings are held daily (mon-fri) with DON, MDS nurse, QA nurse, and nursing staff on duty to discuss any falls that have occurred, nature of event, root cause of fall, any new interventions, care-planning, and if therapy evaluation is needed. These daily meetings will help to ensure that all resident care-planning updates are completed appropriately and timely. These meetings also address resident status changes or concerns so that nursing and MDS nurse can ensure timeliness of care-planning updates. In addition, the MDS nurse has reviewed 75% of resident charts and care plans for any issue related to care planning the resident's needs as a way to ensure no further care- planning deficiencies or lack of following care-plan interventions. 75% of chart audits were completed between 4/6/14-4/23/14. **Systemic Changes:** The policy and procedure for resident special need devices will be updated and revised to include "recliners" when using the word "chair." A list of special care devices will include, but not be limited to,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185343		03/14/2014

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

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F 323	Continued From page 9 stated the facility does not assess the risk versus the benefits of the use of a geri-chair prior to placing residents in the chair. Further interview, on 03/14/14 at 11:35 AM, revealed the facility failed to identify the root cause of the fall, failed to place interventions to prevent reoccurrence; and, failed to update the care plan. 2. Review of the facility's policy titled, "Special Need Devices", last revised 04/01/13, revealed the Director of Nurses (DON), Registered Nurse (RN), and/or Minimum Data Set (MDS) and Care Plan Coordinator will monitor the correct use of and maintain a current listing of Special Devices utilized by the facility residents and those items that could contribute to accidents within the facility. This will include, but not be limited to, the following comfort and safety devices: 1. ant-tipper and anti-roll-back wheelchair devices, 2. Fall mattresses, 3. bed and chair alarms. Record review revealed the facility admitted Resident #2 on 07/01/08 with diagnoses which included Mild Dementia, Mild Micro Albuminea, Cellulitis, Respiratory Distress, and Congestive Heart Failure. Review of the Quarterly MDS assessment, dated 02/20/14, revealed the facility assessed Resident #2's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of a twelve (12) and requiring extensive assistance with activities of daily living. Review of the Comprehensive Care Plan for Risk for Falls and Injury due to weakness, impaired vision, and poor balance, last revised 02/21/14, revealed interventions, dated 02/12/14, for staff to use a pressure pad alarm for bed/chair and to	F 323	Page 10 of 20 special cushions for positioning, anti-rollback/anti-tippers, wheel chair devices, bed alarms, high-back wheelchairs, and recliners when designating chairs. It will include other devices relative to the safety and comfort of residents of the facility. The list of special need devices will be reviewed, updated, and monitored by the MDS \ care plan coordinator and QA Nurse weekly to ensure that the care plans address the use of the special needs devices relative to each specific safety need of each resident and that care is provided according to the care plans instructions. Monitoring has been completed by QA nurse, MDS nurse and\or Administrative RN on 3/14/14, 3/28/14, 4/11/14, & 4/23/14 and will be weekly from here forward. Each resident with a fall alarm now has an "alarm sign" in their room alerting caregivers to ensure proper placement of fall alarm. Completed by MDS nurse on 4/7/14. In addition, the MDS nurse, QA nurse and Administrative RN have reviewed 75% of resident charts and care plans for any issue related to care planning the resident's needs as a way to ensure no further care-planning deficiencies or lack of following care-plan interventions. These chart & care-plan audits were completed between 4/6/14-4/23/14.	

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F 323	Continued From page 10 answer promptly if sounds. Review of Quick Reference Card for Nurse Aides, with no date, revealed Resident #2 required a pressure alarm pad for bed/chair due to fall risk. Observation, on 03/13/14 at 9:15 AM, revealed Resident #2 two Nurse Aide (NA) #1 and NA #2 transferred Resident #2 from the recliner to the bedside commode and there was no pressure alarm on the recliner. Interviews, on 03/13/14 at 9:15 AM with NA #1 and NA #2, revealed there was no chair alarm on the recliner. NA #1 and NA #2 stated there should have been a pressure alarm on the recliner to ensure the staff was aware if the resident attempted to get up and ambulate. Interview, on 03/13/14 at 10:00 AM with Certified Nursing Assistant (CNA) #7, revealed she helped put Resident #2 in the recliner that morning and did not recall an alarm being in the recliner. She stated Resident #2 needed an alarm because he/she tries to get up and could fall on the floor and hurt him/herself and no one would know. Interview, on 03/13/14 at 9:18 AM with Licensed Practical Nurse (LPN) #1, revealed Resident #2 did not have an alarm on his/her recliner and should have had one on the recliner before staff assisted the resident to the recliner. She stated if the resident got up, he/she could fall and no one would know. Interview, on 03/14/14 at 11:50 AM with RN/Floor Supervisor #1, revealed she expected the alarm to be in place to ensure staff would be aware if the resident attempted to get up out of the chair to prevent falls.	F 323	Page 11 of 20 The policy and procedure for the use of g-chair/chair/recliners/bed will be revised to include the following: 1. Chair, refers to g-chair, recliner, other types of chairs, 2. The procedure for applying/ positioning pads to the residents beds and/or chairs, 3. Monitoring the "in use", light, if applicable, to ensure proper operation at the beginning of each shift for all residents utilizing the special safety alarm devices, 4. The charge nurse shall supervise applying an alarm on residents when newly ordered and implemented on the resident care plan. 5. Monitoring the "low battery" warning light and changing the battery if the light is "on." The QA monitoring protocol was reviewed and revised by Administrator on 4/3/14 to include checking proper utilization of alarms weekly as well as added to the resident MAR to be checked each shift by the charge nurses for chair alarms as of 4/3/14. **Monitoring:** The Continuous Quality Improvement CQI program will include reviews of the QA documentation of weekly monitoring of the special care devices use. The CQI protocol relative to Special Devices of the	

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F 323	Continued From page 11 Interview, on 03/14/14 at 10:16 AM with the DON, revealed the staff should follow the care plans and alarms should be in place. The alarm would make staff aware if the resident was attempting to transfer and possible prevent a fall.	F 323	Page 12 of 20 Continuous Quality Improvement Policy and Protocol records will be revised to include recliners whenever the word chairs is referred to. This will ensure that quarterly reviews, observations, and reports reflect adherence to the policy and protocol of the facility. These minutes will reflect quarterly compliance reviews of proper use of special care devices, specifically, bed/chair/recliner alarms and that documentation of the same is regularly maintained within the CQI records. The QA nurse will continue to meet quarterly with the QA committee to discuss portions of the weekly observations of application of the chair/g-chair/recliner alarms and other quality monitoring issues and the need for increased emphasis on training and/or retraining of their use. As well, the alarms for fall prevention were added to the resident's MAR's to ensure nurses are validating each shift that the alarms are in place and functioning properly; added to MARS by QA nurse on 4/3/14. MDS nurse and\or QA nurse will monitor 10% of resident census monthly x 3 months to ensure that new orders, resident condition changes, and\or care-planning needs have been updated AND carried out appropriately and timely. This 3 month period started 4/1/14. These reviews will ensure that care-planned issues are effective and carried out appropriately. QA nurse\team will review these monthly	

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during the 90 day period as the audits are conducted to ensure follow through.

Completed: 4-24-14

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

Corrective Action

On the day of the survey 03/14/14 following a facility investigation of the incident and the establishment of the root cause of the fall, resident #7's care plan was reviewed and revised to include a new intervention and to continue use of the previous alarms. The new intervention added to the care plan was to place Dycem, a slip resistant material, on the seat of the g-chair and to place a cushion mat on the floor in front of the g-chair to help prevent the resident from sliding from the chair and prevent injury should a fall occur. Completed by MDS nurse 3/14/14.

Res #2's alarm was replaced by nursing staff on 3/13/14 when it was noted that the alarm was not inplace during survey.

On the day of the survey 03/13/14 following a facility investigation of the incident to establish why the alarm was not in the proper position; the alarm was

Adm. 4-24-14

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replaced by nursing staff for Res #2.. Resident #2's care plan was reviewed by MDS nurse 3/14/14, pressure pad alarm for bed/chair, answer promptly if sounds will continue. The intervention was modified to state that the alarm was to be placed in the chair/recliner, to ensure that the use of the alarm pad in chair was understood to mean chair, recliner, and/or other types of chairs.

Res #7 was evaluated by Physical Therapist on 4/8/14 to assess risks versus benefits of geri-chair use. Res #7's geri-chair use was deemed appropriate and safe.

Employee shift awareness in-services were conducted on 04/03/14, 04/04/14, 04/05/14, 04/07/2014, and 04/08/2014 by the DON and the MDS coordinator to reinforce proper application and utilization of chair/recliner/bed alarms.

The post fall assessment form was revised on 03/31/14 by Administrator and DON to include establishing the root cause of the fall incident, and include the new intervention, if appropriate, by the investigating nurse.

The policy and procedure for the use of bed/chair/recliner alarms was be revised to include the following:

1. Chair, refers to g-chair, recliner, other chairs when recorded in a care plan,
2. The proper procedure for applying alarms and positioning

Adm 4-24-14

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pads to the resident beds and chairs is in-serviced to the direct care nursing staff,

3. Monitoring the **"in use"** light to ensure proper operation at the beginning of each shift for all residents utilizing the special safety alarm devices,
4. The charge nurse shall supervise applying an alarm on residents when newly ordered and implemented on the resident care plan.
5. Monitoring the **"low battery"** light & changing the batter when light is **"on"**

Identify Others:

All residents identified as having a fall or when special devices, such as, chair/recliner/g-chair/bed alarms are not applied properly have the potential to be affected by the same practice and if the root cause of the incident is not established and a new intervention implemented, if practicable.

The facility DON evaluated\screened all residents in facility utilizing a geri-chair for fall intervention. Completed on 4/4/14. No other residents were identified to have immediate concerns however: Physical Therapy has completed evaluations on Res #7 and one other resident in the facility to assess risks versus benefits of geri-chair use. These 2 residents were deemed

Director Adm - 4-5-14

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appropriate for geri-chair use. MDS nurse has reviewed all care plans on 4/7/14 for careplan accuracy involving falls, type of chair specific to each resident's needs and alarms. No deficiencies noted during these reviews by the MDS nurse on 4/7/14.

On 4/3/14, DON and QA nurse added fall alarms to the applicable MAR's to ensure that each shift the fall alarms are monitored by nursing personnel for proper application and functioning correctly. Nursing will check these alarms and sign off each shift that they have verified proper use and proper functioning alarms on the appropriate residents to prevent accident\hazards.

Systemic Changes:

The policy and procedure for updating and reviewing of care plans following a fall and for monitoring proper usage of bed/chair/recliner/gichair alarms for a facility resident were revised and modified to include the following (by MDS nurse on 4/7/14):

1. The post-fall assessment was revised to include establishing the root cause of the fall by the investigating nurse,
2. The post fall assessment was revised on 03/31/14 to include the documentation of the new intervention implemented,

Admin. 4-24-14

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depending upon the established root cause

3. QA monitoring list was revised on 04/03/2014 to include checking the application of chair alarms to g-chairs and/or recliners, as appropriate. The QA nurse will monitor items on the quality control list 2 x weekly and as necessary.
4. Alarm monitoring for use and proper placement was added to the MAR's for a visual check off on each nursing shift, 7-3, 3-11, 11-7, by the facility nursing staff. This was added to MAR's 4/3/14 by DON and QA nurse.

Geri-chair use for fall prevention protocol has been revised by Administrator and DON on 4/01/14. When the multidisciplinary team decides to use a geri-chair as an appropriate fall intervention, we will do the following:

1. MD will be contacted to request a Physical Therapy order to evaluate for geri-chair use in fall prevention
2. Post evaluation, PT will notify nursing of results and orders will be initiated if warranted
3. Geri-chair used for fall prevention will be added to the resident's medication sheets for nursing to monitor each shift
4. Geri-chair for fall prevention will be added to careplan and caretracker, nursing

Administrator 4-24-14

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documentation system for ease of communication to all nursing staff caring for resident

Employee shift awareness in-services were conducted on 04/03/14, 04/04/14, 04/05/14, 04/07/2014, and 04/08/2014 by the DON and the MDS coordinator to reinforce proper application and utilization of chair/recliner/bed alarms. This protocol will establish routines of visually auditing each nursing work section of the building for the **"in use"** monitoring blinking green light as a visual indication that the alarm is in use and properly applied. The Nursing Care Tracker System will be utilized to ensure regular monitoring and documentation of proper use of the alarms. The use of the bed/chair/recliner alarms will be noted on the MAR's for documentation of the proper **"in use"** visual indicator monitoring during each nursing work shift. This protocol will allow Licensed Nursing staff to ensure that the bed/chair/recliner alarms are in place and functioning properly.

QA monitoring sheets currently being completed by QA nurse 2 x weekly (beginning 3-31-14) include safety monitoring, prevention of accidents \hazards, proper use of fall alarms, prevention of falls, and general safety of residents. QA nurse meets 2xweek with DON and\or Administrative RN to report results of QA monitoring. QA nurse also

Administrator Adm. 4-24-14

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provides immediate education and\or correction if a deficient practice is noted.

Monitoring:

The assistant administrator will continue to maintain record reviews of QA documentation that will include reviews of post fall assessments to ensure that the root cause of a fall was established at the time of the fall or for the prevention of a fall and that a new or current intervention is maintained to prevent falls, if appropriate.

The CQI committee will audit/review QA reports relative to chair alarms being properly applied to g-chairs/chairs/recliners/beds, as appropriate. These audits conducted by the CQI committee will be performed quarterly and identify any deficient practice of applying chair/g-chairs/recliners/bed alarms and will be reported to the Administrative Staff. The Administrative Staff will ensure that re-training and increased comprehension is attained by the nursing staff involved. The administrator will be advised for further staff training and/or chair/g-chair/recliner protocol revision, if necessary.

The QA nurse will continue to meet quarterly with the QA committee to discuss portions of the weekly observations of application of the chair /g-chair/recliner alarms, implementation of new intervention, and other quality monitoring issues and the need for

Admin 4-24-14

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increased emphasis on training and/or retraining in these areas or for revision of the training policy, procedure, and/or protocol.

Even though Resident #2's and Resident #7's use of chair/recliner/g-chair alarms had been corrected immediately following the survey, the facility implemented routine visual monitoring of the appropriate applying of bed/chair/recliner alarms. The QA nurse will conduct visual monitoring rounds weekly and complete reports to be filed with the DON and/or the Adm. Staff relative to proper application and use of bed/chair/recliner alarms.

QA monitoring sheets currently being completed by QA nurse weekly (beginning 3-31-14) include safety monitoring, prevention of accidents \hazards, proper use of fall alarms, prevention of falls, and general safety of residents. QA nurse meets weekly with DON and\or Administrative RN to report results of QA monitoring. QA nurse also provides immediate education and\or correction if a deficient practice is noted.
CQI team will review quarterly the QA monitoring reports to ensure the POC is effective. (CQI team includes but is not limited to: Asst Administrator, DON, Resident Services Coordinator, Department heads, CNA, Administrative RN, MDS nurse, Skin nurse, QA nurse).

Completed: 4-24-14

Adm. 4-24-14

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED
	185343		R 05/07/2014

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{K 000}	INITIAL COMMENTS An onsite Revisit was conducted on 05/07/14 and determined the facility was in compliance on 04/10/14.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1962. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (211). SMOKE COMPARTMENTS: Six (6) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1962 and upgraded in 2009 with a new panel, with 27 smoke detectors and 25 heat detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1962. GENERATOR: Type II generators installed in 2013. Fuel source is Diesel. A Standard Life Safety Code Survey was conducted on 03/13/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-two (72) beds with a census of sixty-five (65) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	**COVINGTON'S CONVALESCENT CENTER, INC.** acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary and findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of the resident. **COVINGTON'S CONVALESCENT CENTER, INC.'S** response to the statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is totally accurate. **K 056 NFPA 101 LIFE SAFETY CODE STANDARD** Corrective Action: On 03/18/14 Covington's Convalescent Center contracted with Pennyrile Fire Safety and Ohio Valley Sprinkler to add additional sprinkler coverage in the medical records office. In accordance with NFPA standards, on 03/28/14: 1. The additional sprinkler device was installed in the medical records office. In addition, discolored sprinkler heads were replaced in the laundry, soiled linen area and the dietary department.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Adm	4-24-14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185343	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/13/2014

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K 000	Continued From page 1 Fire). Deficiencies were cited with the highest deficiency identified at Scope and Severity of an "E".	K 000	Page 2 of 6 **Identify Others:** All facility resident rooms, corridors, central baths, closets, offices, etc. have the potential to be affected by similar findings should 100% sprinkler protection not be provided, obstructed, or not providing equal distribution. Maintenance Supervisor has reviewed the entire facility for proper sprinkler protection on 3/13/14 and no further issues were noted.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for seventy-two (72) beds with a census of sixty-five (65) on the day of the survey. The facility failed to ensure the medical records office had proper sprinkler coverage. According to Centers for Medicare and Medicaid Services Survey & Certification 13-55-Life Safety Code	K 056	**Systemic Changes:** The facility maintenance department has expanded its quarterly visual inspections of all facility departments to ensure that 100% of all areas are sprinkled and that devices are free from discoloration or impediments that may potentially may lead to sprinkler head poor performance, accidental activation, and/or unequal distribution. **Monitoring:** The Contiouous Quality Improvement, CQI, program will include documentation relative to Life Safety quarterly observations/inspections relative the the sprinkler system observations, activation, and distribution capabilities. Quarterly observations of sprinklers will be completed by the Maintenance Supervisor. Completed: 4-10-14	

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	185343		03/13/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K056	Continued From page 2 letter the enforcement implication would be a fully sprinklered facility with minor problems The findings include: Observation, on 03/13/14 at 2:40 PM with the Maintenance Supervisor, revealed the back corner of the medical records office did not have sprinkler protection. Interview, on 03/13/14 at 2:40 PM with the Maintenance Supervisor, revealed he was unaware the room did not have proper sprinkler protection. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed	K 056	 **K 069 NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Action:** On 03/18/14 Covington's Convalescent Center contracted with Pennyrile Fire Safety to relocate the existing dietary hood suppression, manual activation device into the departments path of egress. In accordance with NFPA standards, on 03/26/14 Pennyrile Fire Safety relocated the manual Hood Supression, Activation Device to the path of egress. It has been positioned at the appropriate height above the floor and is clearly identified by signage. **Identify Others:** Covington's has no other cooking dietary facilities requiring manual suppression systems. **Systemic Changes:** The manual hood suppression, activation device is a permanently attached fixture which is installed at NFPA guidelines, height, and identified by the appropriate signage. It is maintained, serviced, and inspected by Pennyrile Fire Safety quarterly inspections and reports. **Monitoring:** The manual hood suppression, activation system is monitored and inspected in	

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K 056	Continued From page 3 maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056	Page 4 of 6 accordance with NFPA Standards by Pennyrile Fire Safety and has 24 hour electronic supervision for emergency operation by Vanguard, Inc. The facility maintenance department monitors the system quarterly for visral signs of lateration or relocation of the activation device through the facility CQI program for any physical damage or system alarm issues. Completed	4-10-14
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure manual activation devices, for the kitchen hood system, were readily available. The deficiency had the potential to affect one (1) of four (4) smoke compartments, ten (10) residents, staff and visitors. The facility is certified for sixty-two (62) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure the manual pull for the hood suppression was located in the egress path. The findings include: Observation, on 03/13/14 at 2:30 PM with the Maintenance Supervisor, revealed the manual activation device for the hood suppression system was not located in an egress path. This was confirmed with the Maintenance Director. Interview, on 03/13/14 at 2:30 PM with the Maintenance Supervisor, revealed he was not aware of the manual activation device being required in a egress path. Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual	K 069	**K 211 NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Action:** On 04/01/14 the facility maintenance supervisor identified and installed a Hand Based /Non Alcohol Based Hand Sanitizer to replace sanitizers identified in rooms # 104, 105, 107, 110, 109, 113, 112, 115, 114, 117, 217, 218, 215, 213, 216, 214, 211, 212, 209, 207, 204, 203, 202, 201. The replacement of all alcohol based hand sanitizer within these rooms was completed on 04/03/14 with the water based sanitizer in order to eliminate any potential ignition source in these rooms. In the future, only water based sanitizer will be utilized by the facility. In-service has been conducted for maintenance, laundry, and housekeeping staff. **Identify Others:** All residents rooms and departments have the potential to be affected by a similar	

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K 069	Continued From page 4 activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.	K 069	Page 5 of 6 practice if alcohol based sanitizer should be installed within the minimum distance from the electrical light switch or other electrical outlets. Maintenance Supervisor has completed an audit of the facility placement of hand sanitizer dispensers Completed 3/14/14.. No other issues were noted. **System Changes:** The facility has elected to change all wall mounted sanitizer products to a Water Based Product. All rooms identified during the survey have had the alcohol based sanitizer removed and replaced with a water based product. In the future, only water based sanitizers will be ordered for the facility.	
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	**Monitoring:** The maintenance, laundry and housekeeping supervisors will monitor usage of all had sanitizer products to ensure only water based products are ordered. CQI will review product purchases, invoices, and shipments for infection control sanitizers quarterly to ensure that all alcohol based wall mount products are neither purchased nor placed within 4 inches of electrical light switch source or other outlet. completed:	4-10-14

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K 211	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed adjacent to an ignition source in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, thirty-two (32) residents, staff, and visitors. The facility is certified for seventy-two (72) beds with a census of sixty-five (65) on the day of the survey. The facility failed to ensure twenty-four (24) alcohol dispensers were not installed adjacent to a light switch. The findings include: Observation, on 03/13/14 between 12:23 PM and 3:00 PM with the Maintenance Supervisor, revealed an Alcohol Based Hand Rub Dispenser installed adjacent to the light switch in resident rooms #104, 105, 107, 110, 109, 113, 112, 115, 114, 117, 217, 218, 215, 213, 216, 214, 211, 212, 209, 207, 204, 203, 202, and 201. Interview, on 03/13/14 at 3:00 PM with the Maintenance Supervisor, revealed an outside company had recently replaced all the dispensers in the facility and he was unaware they were mounted to close to the light switches for the rooms. Reference: NFPA 101 (2000 Edition) Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:	K 211	Page 6 of 6	

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K 211	Continued From page 6 o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		