

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

PRINTED: 03/01/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185167	(X2) MULTIPLE CORRECTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/16/2012
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NAME OF PROVIDER OR SUPPLIER  HOPKINS CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 460 SOUTH COLLEGE STREET WOODBURN, KY 42170
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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
F 000  F 281 SS=D	<p>INITIAL COMMENTS</p> <p>An annual recertification survey was conducted on 02/14/12 through 02/16/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E" with the facility having an opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to provide services that met professional standards of quality for one resident (#2), in the selected sample of twelve residents, related to the failure to administer medications according to written physician's orders.</p> <p>The findings include: A review of the facility's policy/procedure, "General Dose Preparation and Medication Administration," revised 05/01/10, revealed "Prior to administration of medication, facility staff should confirm the MAR reflects the most recent medication order... Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct</p>	F 000  F 281	<p>"This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Hopkins Care and Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency."</p> <p>F281</p> <p>1. The order for lexapro on resident #2 was corrected to reflect 35mg on the medication administration record by the licensed nurse on 2-14-12. Physician orders were obtained for resident #2 medications to be administered at 1030 and 2230 on 2-16-12 by the licensed nurse and the times were corrected on the medication administration record by the licensed nurse on 2-16-12.</p> <p>2. A medication administration audit; comparing physician orders to the (MAR) was completed by the Director of Nursing</p>	

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

*Stephanie [Signature]*

TITLE

*Administrator*

(X6) DATE

*3/8/12*

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 281	<p>Continued From page 1 resident."</p> <p>A record review revealed Resident #2 was admitted to the facility on 09/28/11 with diagnoses to include Closed Fracture, Senile Dementia, Hypertension and Hyperlipidemia.</p> <p>A review of the physician's orders, dated 02/12, revealed an order for Aspirin 81 milligrams (mg) by mouth (po) daily, Bystolic 2.5 mg po daily, Cymbalta 60 mg po daily, Lexapro 35 mg po daily, Lisinopril 5 mg po daily, Tab 'O-Vite 1 tablet po daily, Plavix 75 mg po daily, Namenda 10 mg po twice daily, and Ativan 0.25 mg po twice daily. A review of the physician's orders, dated 02/14/12, revealed Lexapro was changed from 40 mg po once daily to 35 mg po once daily.</p> <p>A review of the Medication Administration Record (MAR), dated 02/12, revealed the administration time for Aspirin 81 mg was at 7:30 AM, Bystolic 2.5 mg po at 7:30 AM, Cymbalta 60 mg po at 7:30 AM, Lexapro 35 mg po at 7:00 AM, Lisinopril 5 mg po at 7:30 AM, Tab 'O-Vite 1 tablet po at 8:00 AM, Plavix 75 mg po at 7:30 AM, Namenda 10 mg po at 7:30 AM and 7:30 PM, and Ativan 0.25 mg po at 10:30 AM and 10:30 PM.</p> <p>An observation of the medication pass, on 02/15/12 at 9:28 AM, revealed Certified Medication Aide(CMA) #1 administered Aspirin 81 mg po, Bystolic 2.5 mg po, Cymbalta 60 mg po, Lexapro 20 mg 2 tablets po, Lisinopril 5 mg po, Tab 'O-Vite 1 tablet po, Plavix 75 mg po, and Namenda 10 mg po to Resident #2.</p> <p>An interview with CMA #1, on 02/15/12 at 1:08 PM, revealed Resident #2 previously resided on</p>	F 281	<p>and Assistant Director of Nursing on 2-29-12 to identify any other physician orders that needed corrections. Physician orders were obtained as needed.</p> <p>3. Re-education of licensed nursing staff and certified medication aides was completed by the Assistant Director of Nursing, to include general dose preparation and medication administration policy and procednrne, along with following a physician order and obtaining physician orders to change any component of an order on 2-16-12.</p> <p>New physician orders will be reviewed in the clinical morning meetings for accuracy by the Director of Nursing and/or Assistant Director of Nursing.</p> <p>4. Medication Administration Technique will be audited by the Director of Nursing and/or the Assistant Director of Nnrnsing monthly for 3 consecutive months and quarterly thereafter for 12 months. Audit results will be discussed in the monthly Performance Improvement meeting for further recommendations.</p> <p>5. Date of correction:</p>	3-11-12
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F 281	<p>Continued From page 2</p> <p>another hall, with a medication administration time at 7:30 AM. She stated the hall which Resident #2 now resides on has a medication administration time at 10:30 AM, therefore she administered the medications according to the hall times. She stated she administered the Ativan at 7:00 AM, and administered the Ativan at that time everyday.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 02/15/12 at 3:14 PM, revealed she received an order to change the Lexapro from 40 mg to 35 mg on 02/14/12. She stated the new 35 mg dose was to start today (02/15/12). She stated pharmacy delivered medications late at night, and if she received an order in the afternoon, she was able to receive the new medications for the following day. She stated she expected the CMA to notify her if the times on the MAR needed to be changed.</p> <p>An interview with Registered Nurse (RN) #1, on 02/15/12 at 3:46 PM, revealed she expected the staff to administer medications according to the times indicated on the MAR.</p> <p>An interview with the Director of Nursing (DON), on 02/15/12 at 4:30 PM, revealed she expected the staff to administer the medications according to the times indicated on the MAR. If anything was questionable, she expected the CMA to notify the nurse to get the medication clarified.</p>	F 281			
F 282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of</p>	F 282	<p>F282</p> <p>1. The sensor pad for resident #7 was placed in the recliner on 2-16-12 at 3:00</p>		

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F 282	<p>Continued From page 3 care.</p> <p>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 implement the care plan for two residents (#7 and #12), in the selected sample of twelve residents. The facility failed to ensure Resident #7's sensor pad alarm was on his/her wheelchair and recliner, and failed to ensure Resident #12 was not left unattended in his/her room.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Care Plan," dated 01/08, revealed "The interdisciplinary team (IDT) develops care plans addressing the resident's most acute problems. The IDT educates the resident/responsible party to the care plan and implements the care plan."</p> <p>1. A closed record review revealed Resident #12 was admitted to the facility on 12/31/10 with diagnoses to include Abnormality of Gait and Senile Dementia.</p> <p>A review of the admission Minimum Data Set (MDS), dated 01/10/11, revealed the facility assessed the resident to be cognitively impaired and he/she required extensive assistance of one staff for transfers.</p> <p>A review of a fall investigation, dated 03/03/11 at 6:15 AM, revealed Resident #12 was in his/her personal recliner at the time the chair alarm</p>	F 282	<p>pm, by the licensed nurse. Resident #12 no longer resides in the facility.</p> <p>2. An audit of other care plans and direct observation of residents with safety devices was conducted by the Director of Nursing and/or the Assistant Director of Nursing on 3-6-12 to ensure residents who are care planned for a device have the device in place.</p> <p>3. Re-education was conducted on 3-1-12 by the Assistant Director of Nursing with nursing staff on following resident care plans and CNA care cards. New orders for devices will be reviewed in the clinical morning meeting by the Director of Nursing Services/Assistant Director of Nursing Services or designee to verify the device is on the resident care plan and care card. Direct observation will be made by The Director of Nursing/Assistant Director of Nursing or designee to verify that the device is in place.</p> <p>4. A review of devices and resident care plans will be completed by the Director of Nursing and/or the Assistant Director of Nursing monthly for 3 consecutive months and quarterly thereafter for 6 months. The audit results will be reviewed in the monthly Performance Improvement meeting for further recommendations.</p> <p>5. Date of correction:</p>	3-11-12	

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F 282	<p>Continued From page 4</p> <p>sounded. Further review revealed when the staff entered the room, they saw Resident #12 in the process of sitting on the floor.</p> <p>A review of the Comprehensive Care Plan, dated 12/31/10, revealed an intervention was added, on 03/03/11, to not leave Resident #12 alone in his/her recliner in the room when the sitter was not present.</p> <p>A review of the fall investigations, dated 04/04/11 at 6:00 PM, 04/12/11 at 12:00 PM, 06/04/11 at 9:15 AM, and 09/06/11 at 12:00 PM, revealed Resident #12 was in his/her room unattended and sustained falls while attempting to transfer and/or ambulate from the recliner.</p> <p>Interviews with Registered Nurse (RN) #1, Licensed Practical Nurse (LPN) #2 and Certified Nurse Aide (CNA) #3, on 02/16/12 at 3:10 PM, at 3:20 PM, and at 3:50 PM, respectively, revealed Resident #12 had a sitter during the day. Whenever the sitter left the resident's room, the sitter did not communicate with staff. They revealed the sitter usually came in around 10:00 AM and left the facility around 6:00 PM.</p> <p>An interview with the Director of Nursing (DON), on 02/16/12 at 4:00 PM, revealed the staff should ensure the resident was not left in his/her room in the recliner unattended.</p> <p>2. A record review reviewed Resident #7 was admitted to the facility on 10/27/06 with diagnoses to include Hypertension, Insomnia, Depression and Dementia.</p> <p>A review of the Comprehensive Care Plan, dated</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>04/10/10, revealed "Risk for falls related to psychotropic medications, impaired balance, unsteady gait, pain, and history of multiple falls," with interventions to include the use of a sensor pad in the wheelchair and on the bed to alert the staff of unsafe transfers.</p> <p>A review of the "Resident Fall Evaluation," dated 01/03/12, revealed the facility assessed the resident to have fall risk factors related to requiring assistance with bed mobility, transfer or ambulation, vision, and receipt of medications which could possibly cause orthostatic blood pressure changes. A review of the quarterly "Device Evaluation," dated 01/03/12, revealed Resident #7 required a sensor pad alarm on his/her wheelchair and recliner due to a history of unassisted transfers.</p> <p>A review of the annual MDS, dated 01/13/12, revealed the facility identified Resident #7 to be moderately cognitively impaired. He/she required extensive assistance of two staff members with transfers and required extensive assistance of one staff member for bed mobility.</p> <p>A review of the Nursing Care Card, dated 02/12, revealed Resident #7 required a chair alarm and a bed alarm.</p> <p>Observations, on 02/14/12 at 9:19 AM, 11:48 AM, 12:20 PM, 4:53 PM, 5:15 PM, on 02/15/12 at 7:42 AM, 10:30 AM, 11:45 AM, 5:07 PM, and on 02/16/12 at 8:55 AM, 10:30 AM, 11:00 AM, 11:55 AM, and 2:25 PM, revealed Resident #7 was sitting in his/her wheelchair or a lift chair with no sensor alarm noted.</p>	F 282		
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F 282	Continued From page 6 Interviews with two CNAs (#1 and #2), on 02/16/12 at 3:15 PM and at 3:22 PM, respectively, revealed they were unaware that Resident #7 required an alarm on his/her wheelchair or recliner. They stated they checked the nurse aide care plans daily and signed them each shift, indicating care was provided.  An interview with LPN #1, on 02/16/12 at 3:26 PM, revealed Resident #7 required a sensor pad alarm on his/her wheelchair and recliner. She expected the CNAs to check and sign the resident's care plan each shift. She stated by signing the care plan, this indicated the CNAs provided care according to his/her individual care plan.  An interview with the DON, on 02/16/12 at 4:14 PM, revealed she expected the staff to check each resident's care plan daily. Whenever the CNA signed the care plan, this indicated they provided care according to each resident's plan of care. She stated Resident #7 was suppose to have sensor alarms on his/her wheelchair and recliner.	F 282		
F 323 SS=E	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	F323  1. A sensor pad for resident #7 was placed in the recliner on 2-16-12 at 3:00 pm, by the licensed nurse. Resident #12 no longer resides in the facility.  2. Resident care plans and nursing assistant care cards were audited by the	

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F 323	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>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 residents (#7 and #12), in the selected sample of twelve residents. The facility failed to ensure Resident #7's sensor pad alarm was on his/her wheelchair and recliner, and failed to ensure Resident #12 was not left unattended in his/her room.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Accidents/Incidents," dated 01/08, revealed "It is the center's policy to provide an environment that is free from hazards over which the center has control. The intent of this policy is that the center identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents."</p> <p>1. A record review reviewed Resident #7 was admitted to the facility on 10/27/06 with diagnoses to include Hypertension, Insomnia, Depression and Dementia.</p> <p>A review of the Comprehensive Care Plan, dated 04/10/10, revealed "Risk for falls related to psychotropic medications, impaired balance, unsteady gait, pain, and history of multiple falls," with interventions to include the use of a sensor pad in the wheelchair and on the bed to alert the staff of unsafe transfers.</p> <p>A review of the "Resident Fall Evaluation," dated</p>	F 323	<p>Director of Nursing and Assistant Director of Nursing on 3-7-12. Direct observation of residents care planned for a safety device was completed by the Director of Nursing and/or the Assistant Director of Nursing on 3-7-12 to verify resident safety and plans of care were being followed.</p> <p>3. Nursing staff were re-educated by the Assistant Director of Nursing on 3-1-12 on the importance of reviewing residents' plans of care and care cards daily prior to signing the care was provided and to directly observe residents to verify safety devices are in place when on a plan of care.</p> <p>4. PI form, Incidents/Accidents System Review (which includes resident name, date and type of incident, MD/family notification, care plan intervention and CNA care card update) will be completed by the Director of Nursing and/or the Assistant Director of Nursing monthly for 3 consecutive months and quarterly for 6 months. Audit results will be reviewed in the monthly Performance Improvement meeting for further recommendations.</p> <p>5. Date of Correction:</p>	3-11-12	

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F 323	<p>Continued From page 8</p> <p>01/03/12, revealed the facility assessed the resident to have fall risk factors related to requiring assistance with bed mobility, transfer or ambulation, vision, and receipt of medications which could possibly cause orthostatic blood pressure changes. A review of the quarterly "Device Evaluation," dated 01/03/12, revealed Resident #7 required a sensor pad alarm on his/her wheelchair and recliner due to a history of unassisted transfers.</p> <p>A review of the annual Minimum Data Set (MDS), dated 01/13/12, revealed the facility identified Resident #7 to be moderately cognitively impaired. He/she required extensive assistance of two staff members with transfers and required extensive assistance of one staff member for bed mobility.</p> <p>A review of the physician's orders, dated 02/12, revealed Resident #7 required a sensor pad alarm on the bed, wheelchair, and recliner. A review of the Nursing Care Card, dated 02/12, revealed Resident #7 required a chair alarm and a bed alarm.</p> <p>Observations, on 02/14/12 at 9:19 AM, 11:48 AM, 12:20 PM, 4:53 PM, 5:15 PM, on 02/15/12 at 7:42 AM, 10:30 AM, 11:45 AM, 5:07 PM, and on 02/16/12 at 8:55 AM, 10:30 AM, 11:00 AM, 11:55 AM, and 2:25 PM, revealed Resident #7 was sitting in his/her wheelchair or a lift chair with no sensor alarm noted.</p> <p>Interviews with two Certified Nurse Aides (CNAs) #1 and #2, on 02/16/12 at 3:15 PM and at 3:22 PM, respectively, revealed they were unaware that Resident #7 required an alarm on his/her</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>wheelchair or recliner. They stated they checked the nurse aide care plans daily and signed them each shift, indicating care was provided.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 02/16/12 at 3:26 PM, revealed Resident #7 required a sensor pad alarm on his/her wheelchair and recliner. She expected the CNAs to check and sign the resident's care plan each shift. She stated by signing the care plan, this indicated the CNAs provided care according to his/her individual care plan.</p> <p>An interview with the Director of Nursing (DON), on 02/16/12 at 4:14 PM, revealed she expected the staff to check each resident's care plan daily. Whenever the CNA signed the care plan, this indicated they provided care according to each resident's plan of care. She stated Resident #7 was suppose to have sensor alarms on his/her wheelchair and recliner.</p> <p>2. A closed record review revealed Resident #12 was admitted to the facility on 12/31/10 with diagnoses to include Abnormality of Gait and Senile Dementia.</p> <p>A review of the admission MDS, dated 01/10/11, revealed the facility assessed the resident to be cognitively impaired and he/she required extensive assistance of one staff for transfers.</p> <p>A review of the Comprehensive Care Plan, "At risk for falls," dated 12/31/10, revealed an intervention for an alarm on the resident's recliner. Further review of the Comprehensive Care Plan revealed revisions were made and an intervention was added, on 03/03/11, to not leave</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  HOPKINS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 460 SOUTH COLLEGE STREET WOODBURN, KY 42170		
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F 323	<p>Continued From page 10</p> <p>the resident alone in the recliner in his/her room whenever the sitter was not present.</p> <p>A review of a fall investigation, dated 03/03/11 at 6:15 AM, revealed Resident #12 was in his/her personal recliner at the time the chair alarm sounded. Further review revealed when the staff entered the room, they saw Resident #12 in the process of sitting on the floor.</p> <p>Further review of fall investigations, dated 04/04/11 at 6:00 PM and 04/12/11 at 12:00 PM, revealed Resident #12 was left in his/her room unattended and sustained falls attempting to self-transfer and ambulate from the recliner. Review of the investigations revealed the facility failed to identify the resident's care plan was not followed related to not leaving the resident in his/her room unattended in the recliner. No further interventions were put in place to address the resident being left in his/her room unattended.</p> <p>A review of a fall investigation, dated 06/04/11 at 9:15 AM, revealed Resident #12 was left in his/her room unattended when he/she attempted to self-transfer from the recliner. The alarm sounded and the resident sat on the floor before the staff could get to him/her. Further review of the investigation revealed an intervention was put in place to keep Resident #12 in common areas whenever the sitter/family was not in the room.</p> <p>A review of a fall investigation, dated 09/06/11 at 12:00 PM, revealed Resident #12 was found in his/her room unattended, sitting on the floor in front of the recliner. Further review of the investigation revealed an intervention was added to put dycem in the seat of the recliner. The</p>	F 323			

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F 323	Continued From page 11 facility failed to identify Resident #12 was left in the room unattended and was not kept in the common area.  Interviews with Registered Nurse (RN) #1, LPN #2 and CNA #3, on 02/16/12 at 3:10 PM, at 3:20 PM, and at 3:50 PM, respectively, revealed Resident #12 had a sitter during the day. Whenever the sitter left the resident's room, the sitter did not communicate with staff. They revealed the sitter usually came in around 10:00 AM and left the facility around 6:00 PM.  An interview with the DON, on 02/16/12 at 4:00 PM, revealed the staff should ensure the resident was not left in his/her room in the recliner unattended. She revealed a conversation was held with the sitter to reinforce notification of the staff whenever she left the resident's room. However, the DON could provide no evidence of the discussions with the sitter and no evidence any further action was taken whenever the resident continued to be left in the room unattended.	F 323			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F332		
	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 ensure that it was free of a medication error rate of 5% or		1. Physicians and responsible parties for residents # 2, #10, and #16 were contacted by the Director of Nursing on 2-17-12 related to the medication administration of these residents. Residents were assessed by the Director		

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F 332	<p>Continued From page 12</p> <p>greater. Observations of a medications pass, on 02/14/12 and on 02/15/12, revealed there were a total of 47 opportunities with five medication errors, which resulted in a 10% medication error rate.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "General Dose Preparation and Medication Administration," revised 05/01/10, revealed "Prior to administration of medication, facility staff should confirm the MAR reflects the most recent medication order. Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident."</p> <p>1. A record review revealed Resident #10 was admitted to the facility on 12/18/11 with diagnosis to include Restless Leg Syndrome.</p> <p>A review of the physician's orders, dated 02/12, revealed to administer Gabapentin (Central Nervous System drug) 400 milligrams (mg) at bedtime (hs). A review of the Medication Administration Record (MAR), dated 02/12, revealed to administer Gabapentin 400 mg at bedtime (hs) every day.</p> <p>An observation of a medication pass, on 02/14/12 at 7:55 AM, revealed Certified Medication Aide (CMA) #1 administered Gabapentin 400 mg by mouth (po) to Resident #10.</p> <p>2. A record review revealed Resident #16 was admitted to the facility on 09/01/10 with diagnosis</p>	F 332	<p>of Nursing on 2-17-12 with no signs or symptoms of adverse reactions.</p> <p>Certified Medication Aide# 1 was re-educated by the Director of Nursing on 2-16-12 on following physician orders for the correct resident, the correct medication, the correct dose, the correct route and the correct time.</p> <p>2. A Medication Administration Record audit along with review of physician orders was conducted by the Assistant Director of Nursing on 2-29-12 to ensure accuracy of orders.</p> <p>3. Re-education of the licensed nursing staff and certified medication aides was conducted on 2-16-12 by the Assistant Director of Nursing that included ensuring the five rights of medication administration; the correct resident, the correct time, the correct medication, the correct dose and the correct route and following physician orders.</p> <p>Nursing staff administering medications will be monitored at random 1 x weekly x 4 weeks, then monthly x 3 months by the Director of Nursing and/or the Assistant Director of Nursing with any additional education as needed.</p>		

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F 332	<p>Continued From page 13 to include Hypothyroidism.</p> <p>A review of the physician's order, dated 02/12, revealed to administer Synthroid 75 micrograms (mcg) po daily. A review of the MAR, dated 02/12, revealed to administer Synthroid 75 mcg daily at 6:00 AM.</p> <p>An observation of a medication pass, on 02/14/12 at 8:10 AM, revealed CMA #1 administered Synthroid 75 mcg po.</p> <p>A review of the Mosby's Nursing Drug Handbook, 2011, revealed to administer Synthroid each day, preferably before breakfast.</p> <p>An interview with CMA #1, on 02/15/12 at 1:10 PM, revealed Resident #16 was suppose to receive Gabapentin at 7:30 AM, however, after reviewing the MAR, she stated she did not recall administering the Gabapentin at 8:10 AM. She stated she received an extra bag of medication that morning and she had to sort through them, which caused her to start her medication pass late. She stated this caused her to administer Resident #17's Synthroid at 7:55 AM, instead of 6:00 AM.</p> <p>3. A record review revealed Resident #2 was admitted to the facility on 09/28/11 with diagnoses to include Closed Fracture, Senile Dementia, Hypertension and Hyperlipidemia.</p> <p>A review of the physician's orders, dated 02/12, revealed an order for Namenda 10 mg po twice daily, Lexapro 35 mg po once daily, and Ativan 0.25 mg po twice daily. A review of the physician's orders, dated 02/14/12, revealed</p>	F 332	<p>4. PI form, Medication Administration Technique, ( which includes the 5 rights of medication administration, correct resident, correct time, correct medication, correct dose and correct route will be completed monthly x 6 months, then quarterly for the next 6 months by the Director of Nursing/or Assistant Director of Nursing and the results will be brought to the Performance Improvement Committee for further recommendations.</p> <p>5. Date of Correction:</p>	3-11-12
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F 332	<p>Continued From page 14</p> <p>Lexapro was changed from 40 mg po once daily to 35 mg po once daily.</p> <p>A review of the MAR, dated 02/12, revealed the administration time for Namenda 10 mg was at 7:30 AM and 7:30 PM, Lexapro 35 mg po at 7:00 AM, and Ativan 0.25 mg po at 10:30 AM and 10:30 PM.</p> <p>An observation of a medication pass, on 02/15/12 at 9:28 AM, revealed CMT #1 administered Lexapro 40 mg po, and Namenda 10 mg po to Resident #2. The CMT did not administer the Ativan.</p> <p>An interview with CMA #1, on 02/15/12 at 1:08 PM, revealed Resident #2 previously resided on another hall, with the medication administration time at 7:30 AM. She stated the hall that Resident #2 resides on has a medication administration time of 10:30 AM, therefore she administered the medications according to the hall times. She stated she administered the Ativan at 7:00 AM, and administered the Ativan at that time everyday.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 02/15/12 at 3:14 PM, revealed she received an order to change the Lexapro from 40 mg to 35 mg on 02/14/12. She stated the new 35 mg dose was to start today (02/15/12). She stated pharmacy delivered medications late at night, and if she received an order in the afternoon, she was able to receive the new medications for the following day. She stated she expected the CMT to notify her if the times on the MAR needed to be changed.</p>	F 332			

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F 332	Continued From page 15 An interview with Registered Nurse (RN) #1, on 02/15/12 at 3:46 PM, revealed she expected the staff to administer medications according to the times indicated on the MAR.  An interview with the Director of Nursing (DON), on 02/15/12 at 4:30 PM, revealed she expected the staff to administer the medications according to the times indicated on the MAR. If anything was questionable, she expected the CMT to notify the nurse to get the medication clarified.	F 332			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1960, 1978</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is liquid propane.</p> <p>A standard Life Safety Code survey was conducted on 0214/12. Hopkins Care and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for fifty (50) beds and the census was forty five (45) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>"This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Hopkins Care and Rehabilitation Center does not admit that the deficiency exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Stephanie Dign...* TITLE Administrator (X6) DATE 3/8/12

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

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K 000	Continued From page 1	K 000	K025		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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</p> <p>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 potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for fifty (50) beds with a census of forty five (45) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/14/12 at 2:15 PM, with the Maintenance Director revealed the smoke partitions extending above the ceiling throughout the facility were not safely accessible. The facility</p>	<p>1. The Maintenance Director conducted a review of the fire walls on 3-7-12 to ensure smoke barriers are being maintained to resist smoke per NFPA standards. Smoke barriers were repaired by Maintenance Director on 3-7-12.</p> <p>2. The Maintenance Director inspected other fire walls on 3/7/2012 and no other smoke barriers required repair.</p> <p>3. Maintenance Director was re-educated on 3-5-12 by the Administrator on conducting routine checks of fire walls to ensure they are maintained to resist smoke according to NFPA 101 standards.</p> <p>4. Maintenance Director will conduct reviews of the facilities fire walls on a quarterly basis and report to the Performance Improvement Committee quarterly for 6 months for further recommendations.</p> <p>5. Date of Correction:</p>	3-11-12		

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K 025	<p>Continued From page 2</p> <p>had installed a chemical dust in 2009 called Drione that was manufactured by the Bayer Corporation. The chemical required PPE that was not available from the facility.</p> <p>Interview, on 02/14/12 at 2:15 PM, with the Maintenance Director and the Administrator revealed the smoke barriers in the attic had not been checked for two years. Further interview revealed the sprinklers in the attic had not been checked due to the Drione chemical in the attic. A call to the Bayer Corporation revealed they considered the attic safe to enter because several years had passed since the chemical had been installed. An attempt to check the smoke barrier by the surveyor caused redness to his hand and severe itching. Further attempts were not feasible for safety concerns.</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 building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(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</p>	K 025		



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K 027	<p>Continued From page 4</p> <p>Observation, on 02/14/12 between 2:15 PM and 5:00 PM, with the Maintenance Director revealed the cross-corridor doors located next to laundry and next to the front dining area, would not close completely when tested, due to the doors not having a coordinator to ensure the door without the t-astragal would close first.</p> <p>Interview, on 02/14/12 between 2:15 PM and 5:00 PM, with the Maintenance Director revealed they were unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access</p>	K 027	<p>K038</p> <ol style="list-style-type: none"> <li>1. The mini blinds were removed from the (2) exit doors on 2-15-12 by the Maintenance Director.</li> <li>2. The Maintenance Director conducted a review on 2-15-12 of the other exit doors and no other mini blinds were identified.</li> <li>3. The Maintenance Director has been educated on exit doors being maintained to be clearly recognizable as a means of egress by the Administrator on 3-5-12.</li> </ol>	
K 038 SS=D		K 038		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185167	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  02/14/2012
NAME OF PROVIDER OR SUPPLIER  HOPKINS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 460 SOUTH COLLEGE STREET WOODBURN, KY 42170		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	Continued From page 5 and exit doors were maintained to be clearly recognizable as a means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartment, residents, staff and visitors. The facility is licensed for fifty (50) beds with a census of forty five (45) on the day of the survey.  The findings include:  Observation, on 02/14/12 at 5:45 PM, with the Maintenance Director revealed mini-blinds mounted on two (2) exit doors located by room # 20, and # 27.  Interview, on 02/14/12 at 5:45 PM, with the Maintenance Director revealed they were unaware that mini-blinds had the potential to disguise the exits from being clearly recognizable.  Reference: NFPA 101 (2000 Edition)  7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit.	K 038	4. The Maintenance Director will conduct monthly audits of the egress doors and report the results to the Performance Improvement Committee monthly x 6 months for further recommendations.  Date of compliance:	3-11-12	
K 045 SS=F	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	K 045	K045  1. Light fixtures with double bulbs have been installed outside of room #2, #20, and outside of the administrative offices, deck exit, main front entrance, dietary exit, and the north rear exit by the		

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K 045	<p>Continued From page 6</p> <p>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 three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for fifty (50) beds with a census of forty five (45) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/14/12 between 2:00 PM and 5:00 PM, with the Maintenance Director revealed the exterior exits next to room 2, 20, and next to the administrator 's office were equipped with a single bulb for illuminating egress path to the public way from the exit.</p> <p>Interview, on 02/14/12 between 2:00 PM and 5:00 PM, revealed the Maintenance Director was unaware the lighting fixtures serving the exterior exits must include more than one bulb.</p> <p>Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness.</p> <p>Reference: NFPA 101 (2000 edition) 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</p>	K 045	<p>Maintenance Director on 3-8-12.</p> <p>2. The Maintenance Director checked other egress passages for the proper light fixtures on 2-15-12 and no others were identified.</p> <p>3. The Maintenance Director has been re-educated by the Administrator on 3-5-12 on the illumination of means of egress.</p> <p>4. The Maintenance Director will conduct weekly audits of the illumination of the egress passages and report to the Performance Improvement Committee monthly for the next 6 months for further recommendations.</p> <p>Date of Compliance :</p>	3-11-12	

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K 045	Continued From page 7 level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	<p>K048</p> <ol style="list-style-type: none"> <li>1. A fire safety plan was put in place by the Administrator on 3-8-12 that states what actions the staff are to execute in the event of a fire emergency.</li> <li>2. Employee staff have been educated on the policy and procedure of the fire safety plan by the Administrator and the Safety Committee Chairman by 3-10-12 New employees will be educated during orientation and all staff at least annually.</li> <li>3. Employee staff have been educated on the policy and procedure of the fire safety plan by the Administrator and the Safety Committee chairman by 3-10-12.</li> <li>4. The fire safety plan will be presented to the Performance Improvement Committee on the next scheduled committee date by the Administrator for recommendations. Thereafter, the Administrator will bring the Fire Safety Program annually to the Performance Improvement Committee for review and recommendations.</li> </ol> <p>Date of Compliance:</p>	3-11-12	
K 048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>This STANDARD is not met as evidenced by: Based on policy review, and interview it was determined the facility failed to provide a Fire Safety Plan and Procedure Policy in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty (50) beds with a census of forty five (45) on the day of the survey.</p> <p>The findings include:</p> <p>Policy review, on 02/14/12 at 2:15 PM revealed the facility failed to provide a Fire Safety Plan and Procedure Policy that states what actions the facility staff are execute in the event of an emergency situation.</p> <p>Interview, on 02/14/12 at 2:15 PM with the Maintenance Director revealed he did not know why the facility did not have a Fire Safety Plan.</p> <p>Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1</p>	K 048			

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K 048	Continued From page 8 The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the	K 048			

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K 048	Continued From page 9 removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy 's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and	K 048		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050	K050  1. A fire drill was conducted at random by the Maintenance Director on 2-27-12.	

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K 050	<p>Continued From page 10 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty (50) beds and the census was forty five (45) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 02/14/12 at 12:53 PM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. First shift fire drills were being conducted predictably between 9:00 AM and 10:00 AM, second shift at 3:00 PM, and third shift at 5:00 AM. This observation was confirmed with the Administrator at the exit conference.</p> <p>Interview, on 02/15/12 at 12:53 AM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required.</p>	K 050	<p>2. Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift by the Maintenance Director or designee.</p> <p>3. The Maintenance Director has been re-educated by the Administrator on 3-5-12 on the fire drill policy and drills being conducted at varying times and randomly.</p> <p>4. Fire Drill results will be brought to the Performance Improvement Committee by the Maintenance Director monthly for 6 months for further recommendations.</p> <p>Date of Compliance:</p>	3-11-12	

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K 050	Continued From page 11	K 050		
K 056 SS=D	<p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty (50) beds with a census of forty five (45) on the day of the survey.</p> <p>The findings include:</p>	K 056	<p>K056</p> <ol style="list-style-type: none"> <li>1. Sprinkler heads have been installed at the exits by rooms #26 and #21 by Eagle Fire Protection by on 3-6-12.</li> <li>2. The facility was reviewed by the Maintenance Director on 3-1-12 for other areas that may require sprinkler heads and no other areas were in need of additional sprinkler heads.</li> <li>3. The Maintenance Director has been re-educated by the Administrator on 3-5-12 on the sprinkler system requirements.</li> <li>4. The sprinkler system will be inspected quarterly by Eagle Fire Protection. The reports will be presented by the Maintenance Director to the Performance Improvement Committee quarterly for 6 months for further recommendations.</li> </ol> <p>Date of Compliance:</p>	3-11-12

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K 056	Continued From page 12  Observation, on 02/14/12 between 2:30 PM and 3:30 PM, with the Maintenance Director revealed that the exit next to room 26 and the exit next to room 21 did not have sprinkler coverage under the porches that extend over 4' and are made of combustibile material.  Interview, on 02/14/12 between 2:30 PM and 3:30 PM, with the Maintenance Director revealed he was not aware the porches needed to be sprinkler protected.  Reference: NFPA 13 (1999 Edition) 5-13 8.1  Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustibile construction. Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustibile supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied	K 056			

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K 056	Continued From page 13 portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 056			
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty (50) beds with a census of forty five (45) on the day of the survey.  The findings include:  Observation, on 02/14/12 at 4:55 PM, with the Maintenance Director revealed a heavy build up of lint behind the washer and dryer and in the top of the dryer, in the Laundry Room.  Interview, on 02/14/12 at 4:55 PM, with the Maintenance Director revealed he was not aware the lint build up was so excessive.	K 130	K130  1. The lint buildup behind the washer and dryer and the top of the dryer was cleaned on 2-15-12 by the Maintenance Director.  2. The laundry area was checked by the Maintenance Director on 2-15-12 for any other excess lint/dust. No other areas were identified.  3. The Maintenance Director has been re-educated on maintenance of hazardous areas by the Administrator on 3-5-12.  4. The Maintenance Director will conduct environmental reviews of the laundry area twice weekly and report results to the Performance Improvement Committee monthly for 6 months for further recommendations.  5. Date of Correction:	3-11-12	

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K 130	Continued From page 14  Reference: NFPA 101 (2000 Edition)	K 130			