

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

PRINTED: 08/19/2010  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701
--	--

(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	F 000	"Preparation and execution of this Plan of Correction does not constitute admission or agreement of any alleged deficiencies cited in this document. This plan of correction is prepared and executed as required under the provisions of federal and state law. Further Helmwood Healthcare Center reserves the rights to dispute the deficiencies in any other forum if necessary."	8/25/10
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE  A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)  This REQUIREMENT is not met as evidenced by: Based on interview and record reviews, it was determined the facility failed to complete a significant change MDS (Minimum Data Set) assessment for one Resident (#5) in the select sample of 15, who returned from the hospital after sustaining a hip fracture. Findings include:  Resident #5 was admitted on 05/15/09 with diagnoses to include Parkinson's Disease and	F 274	1) The care plan for resident #5 was reviewed by the Interdisciplinary Team and revised on 08/25/10 to included Parkinson's Disease, Dementia with Behavioral Disturbance and fall prevention. A significant change assessment will be completed if there are any declines in activities of daily living. The Interdisciplinary Team was provided reeducation by the MDS nurse on 8/16/10 on conditions that warrant significant change assessment.  2) Helmwood Healthcare now has an MDS nurse completing the comprehensive assessment within 14 days after the center has determined that there has been a significant change in the resident's physical or mental condition.  3) Due to the difficulty in filling the position of MDS Coordinator, the Executive Director and DON elected to train a nurse already on staff at the center to fulfill this position. A professional MDS trainer will start on 9/7/10 to provide thorough training. Until this training is complete, MDS assessments will be complete by the MDS nurse from a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Jaron Jones</i>	TITLE  <i>Administrator</i>	(X6) DATE  8/27/10
---	-----------------------------------	--------------------------

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.

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

PRINTED: 08/19/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/13/2010
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701		
(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 274	<p>Continued From page 1</p> <p>Dementia with Behavioral Disturbance. A review of the MDS assessments revealed an admission assessment, dated 05/21/09; a quarterly assessment, dated 08/18/09; and a quarterly assessment, dated 11/16/09. After a fall with a fracture during an unassisted transfer, the resident was sent to the local hospital on 02/05/10 with a return anticipated. The resident returned from the hospital on 02/09/10. Although the resident returned from the hospital on 02/09/10 with declines in his/her ability to complete activities of daily living (ADL), a significant change assessment was not completed. Physical and Occupational therapies, dietary and nursing disciplines made revisions to the resident's care plan that reflected these declines. However, instead of completing a significant change assessment, the facility completed a quarterly assessment on 03/02/10, that showed declines in ambulation, weight, incontinence, range of motion and falls.</p> <p>An interview, on 08/13/10 at 9:05 AM, with the Clinical Systems Coordinator revealed the facility currently did not employ an MDS coordinator. She also stated there had been five MDS Coordinators in the past year. The last person to hold that position was a temporary service employee, who went on vacation and did not return. There was a default report sent to facilities when MDS assessments were behind and the facility was aware there was a problem, but could not get the staff hired and trained quickly enough to remedy the problem. The Clinical Systems Coordinator also stated if the resident had an illness or fall with a fracture, a decrease in mobility or change in two or more ADL scores, this would be an indication for a significant change assessment. She also stated</p>	F 274	<p>sister facility under the supervision of the Clinical System Coordinator.</p> <p>4) The MDS nurse will audit to ensure that the above measures result in the completion of comprehensive assessment after all significant changes. Auditing will continue until twelve weeks of 100% compliance is met.</p> <p>5) Trends identified will be reviewed at the monthly by the Quality Assurance Committee for any additional follow up and/or in-services needs.</p>		

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

PRINTED: 08/19/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/13/2010
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701	
(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 274	Continued From page 2 weight increase or decrease alone could trigger a significant change assessment and the resident should have had a significant change assessment.	F 274		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS  A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to submit a quarterly Minimum Data Set (MDS) assessment for one resident (#9) in the selected sample of 15. The resident was due a quarterly assessment on 07/02/10, but it was not completed. Findings include:  Resident #9 was admitted to the facility on 12/19/07 with diagnoses to include Dementia, Diabetes, Recurrent Dislocation of the pelvis, Alzheimer, Osteoporosis and Hypertension. Resident #9 had an annual assessment completed on 12/07/09, a quarterly assessment completed on 04/27/10 and another quarterly assessment due on 07/20/10. There was no documented evidence this assessment was completed.  An interview with the Clinical Systems Coordinator, on 08/13/10 at 1:30 PM, revealed a quarterly assessment was due for Resident #9 but was not completed. She stated the multiple turn overs in the MDS Coordinator position led to	F 276	1) The care plan for resident #9 was reviewed by the Interdisciplinary Team and revised on 08/25/10 to included Dementia, Diabetes, Recurrent Dislocation of the pelvis, Alzheimer, Osteoporosis and Hypertension. A significant change assessment will be completed if there are any declines in activities of daily living. The Interdisciplinary Team was provided reeducation by the MDS nurse on 8/16/10 on quarterly assessments.  2) Helmwood Healthcare MDS nurse completed the quarterly assessment of resident #9 on 8/15/10.  3) Due to the difficulty in filling the position of MDS Coordinator, the Executive Director and DON elected to train a nurse already on staff at the center to fulfill this position. A professional MDS trainer will start on 9/7/10 to provide thorough training. Until this training is complete, MDS assessments will be complete by the MDS nurse from a sister facility under the supervision of the Clinical System Coordinator.	8/25/10

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

PRINTED: 08/19/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/13/2010
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701		
(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 276	Continued From page 3 confusion and inaccuracy of some MDS assessments.	F 276	4) The MDS nurse will audit to ensure that the above measures result in the completion of quarterly assessments. Auditing will continue until twelve weeks of 100% compliance is met.		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to accurately assess one resident (#2), in the select sample of 15, in	F 278	5) Trends identified will be reviewed at the monthly by the Quality Assurance Committee for any additional follow up and/or in-services needs.  1) The care plan for resident #17 was reviewed by the Interdisciplinary Team to include Depressive Disorder Dementia, Raynaud's Syndrome and Paralysis Agitans and revised on 08/25/10. A care plan for resident #2 was reviewed by the Interdisciplinary Team to include Cerebral Vascular Accident (CVA) with Late Effect Hemiplegia and Coronary Artery Disease and revised on 8/25/10.  2) Helmwood Healthcare MDS nurse completed the MDS's of resident #2 and resident #17 to verify the accuracy/coordination/certification of assessments on 8/16/10.  3) Due to the difficulty in filling the position of MDS Coordinator, the Executive Director and DON elected to train a nurse already on staff at the center to fulfill this position. A professional MDS trainer will start on 9/7/10 to provide thorough training. Until this training is complete, MDS assessments will be complete by the MDS nurse from a sister facility under the supervision of the Clinical System Coordinator.	8/25/10	

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

PRINTED: 08/19/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/13/2010
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701		
(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 278	<p>Continued From page 4</p> <p>related to the initial comprehensive assessment that should reflect an accurate baseline determination of the resident's progress. In addition, the facility failed to ensure the appropriate disciplines signed and certified the assessment was complete for one resident (#17,) not in the select sample of 15. Findings include:</p> <p>1. Resident #17 was admitted to the facility on 02/13/09 with diagnoses to include Depressive Disorder Dementia, Raynaud's Syndrome and Paralysis Agitans. The facility assessed Resident #17 as requiring extensive assistance with bed mobility and transfers and having limited assistance with ambulation. He/she required assistance with dressing, toilet use and personal hygiene.</p> <p>A review of the Minimum Data Set (MDS) annual assessment, dated 12/14/09, revealed a single signature from a Registered Nurse (RN). No signatures from other disciplines could be verified.</p> <p>An interview with the Clinical Systems Coordinator, on 08/13/10 at 1:30 PM, revealed multiple disciplines were to sign the MDS to attest to the accuracy of the their portion of the assessment. She stated the disciplines did not sign and should have. Additionally, she stated the multiple turn overs in the MDS Coordinator position led to confusion and inaccuracy of some MDS assessments.</p> <p>2. Resident #2 was admitted on 12/07/09 with diagnoses to include a Cerebral Vascular Accident (CVA) with Late Effect Hemiplegia and Coronary Artery Disease.</p>	F 278	<p>4) The MDS nurse will notify the Interdisciplinary team when assessments are ready to be signed. Each team member will verify the accuracy of his/her section of the MDS assessments before signing. The MDS nurse will be responsible for ensuring that all disciplines have signed each assessment.</p> <p>5) Trends identified will be reviewed at the monthly by the Quality Assurance Committee for any additional follow up and/or in-services needs.</p>		

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

PRINTED: 08/19/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/13/2010
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701		
(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 278	<p>Continued From page 5</p> <p>A review of the admission MDS, dated 12/18/09, revealed the facility assessed the resident as having full range of motion in all extremities. A review of the most recent quarterly assessment, dated 06/09/10, revealed the resident had limitations on one side in his/her arms and hands.</p> <p>A review of the Physical Therapy (PT) Evaluation, completed two days after admission on 12/08/09, revealed the resident experienced left sided weakness following a CVA in November of 2008 with a residual decrease in strength, balance and endurance.</p> <p>An interview, on 08/13/10 at 9:45 AM, with the Clinical Systems Coordinator revealed the resident had Hemiplegia on admission on 12/07/09. The MDS Coordinator, at the time, had incorrectly evaluated the resident's ROM or had not read the PT Evaluation, or had not coordinated with the PT in the resident's initial comprehensive assessment. However, neither the PT or the MDS Coordinator was currently employed at the facility and was unavailable for an interview.</p>	F 278			

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

PRINTED: 08/20/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2010
--	--	--	--



NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS	K 000		
K 018 SS=D	<p>A life safety code survey was initiated and concluded on August 12, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that corridor doors were being held open by approved devices. The findings include:</p>	K 018	<p>"Preparation and execution of this Plan of Correction does not constitute admission or agreement of any alleged deficiencies cited in this document. This plan of correction is prepared and executed as required under the provisions of federal and state law. Further Helmwood Healthcare Center reserves the rights to dispute the deficiencies in any other forum if necessary."</p> <p>1) The drop down devices were removed from the facility on 8/13/10. Hold-open devices that release when the door is pushed or pulled were installed to replace the drop down devices on 8/18/10.</p> <p>2) All staff has been reeducated by the maintenance director that drop down devices cannot be used in a long term care facility. Monitoring will be a daily routine by the maintenance department/designee all shifts.</p> <p>3) The monitoring program to assure no drop down devices are in the center and only hold-open devices are in the facility will be done daily by the maintenance department/designee.</p> <p>4) Trends identified will be reviewed at the monthly by the Quality Assurance Committee/Safety Committee for any additional follow up and/or in-services needs.</p>	8/18/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Jason Jones</i>	TITLE  <i>Administrator</i>	(X6) DATE  8/27/10
---	-----------------------------------	--------------------------

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.

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

PRINTED: 08/20/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2010
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701	
(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 018	Continued From page 1  During the Life Safety Code tour on August 12, 2010, at 9:15 a.m., with the Director of Maintenance, the first floor Therapy doors were observed to be held open with drop-down devices located at the bottom of the doors. Doors cannot be held open in this manner. An interview with the Director of Maintenance revealed he state he was told by a pervious surveyor that drop down door hold open devices were permitted to be used.  Reference: NFPA 101 2000 edition  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.  19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When	K 029	1) An automatic door closing device has been installed in Medical Records and rooms deemed to be a hazardous area on 8/18/10. Automatic door closing devices will be installed throughout the facility at the time of the installment of the new alarm system. A quote has been requested and will be available on 8/27/10.	8/27/10

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

PRINTED: 08/20/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2010
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	<p>Continued From page 2</p> <p>the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that hazardous area doors were equipped with a self-closing device. The findings include:</p> <p>During the Life Safety Code tour on August 12, 2010, at 9:00 a.m., with the Director of Maintenance, a corridor door to the first floor Medical Records room was observed not to have a door closing device. Door closing devices are required on doors to rooms deemed to be a hazardous area. An interview revealed the Director of Maintenance was unsure which rooms were considered hazardous that would require a door closing device.</p> <p>Reference: NFPA 101 2000 edition</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be</p>	K 029	<p>2) All staff has been reeducated by the maintenance director that only automatic door closing devices can be used in rooms deemed to be a hazardous area in a long term care facility. Monitoring will be a daily routine by the maintenance department/designee all shifts.</p> <p>3) The monitoring program to assure automatic door closing devices are working properly in hazardous rooms will be done daily by the maintenance department/designee.</p> <p>4) Trends identified will be reviewed at the monthly by the Quality Assurance Committee/Safety Committee for any additional follow up and/or in-services needs.</p>	