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OFFICE OF INSPECTOR GENERAL

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

PRINTED: 09/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701
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F 000	<p>INITIAL COMMENTS</p> <p>A standard recertification survey was initiated on 08/28/13 and concluded on 08/30/13 with deficiencies cited at the highest scope and severity of a "D" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition. A Life Safety Code survey was conducted on 09/05/13 with deficiencies cited at the highest scope and severity of an "F".</p> <p>An abbreviated survey to investigate KY 20602 was conducted 08/28/13 through 08/30/13 in conjunction with the standard recertification survey. The Division of Health Care unsubstantiated the allegation; however, related deficiencies were cited.</p>	F 000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement of any alleged deficiencies cited in the 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>	
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and</p>	F 225	<p>F 225: Initial and five day follow up report on misappropriation of funds for Resident #8 was completed and faxed to OIG and DCBS on 8.30.2013. Elizabethtown City Police were also notified on 8.30.2013.</p> <p>Staff were questioned regarding any other residents reports of missing money. Staff have not been informed of any other residents having monies missing; therefore, no other residents were affected.</p> <p>Staff Development Coordinator(SDC) immediately in serviced the administrator and all department managers on immediate notification to state agencies on 8.30.2013 related to the facility's abuse policy. All staff were in serviced by SDC on</p>	

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

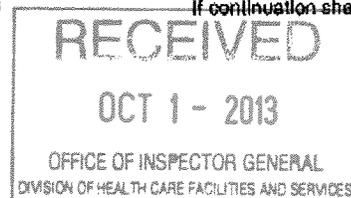
X One Man Executive Director X 10/1/13

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

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F 225	Continued From page 1 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's Abuse Investigation policy, it was determined the facility failed to ensure one (1) of the two (2) allegations of misappropriation of property was immediately reported to the Office of Inspector General (OIG) upon notice for Resident #8. The facility failed to report an allegation reported to them by Resident #8 when the resident told the facility he/she was missing twenty (20) dollars on 08/21/13 which was not reported to the OIG until the resident notified the state surveyors during a combined standard survey and an investigation for misappropriation of property on 08/30/13. The findings include: Review of the facility's policy Abuse	F 225	(continued from p. 1) 9.1.2013 through 9.25 2013 on the abuse policy and reporting immediately. Staff will continue to be in serviced regarding abuse policy no less frequently than annually. Administrator/DON/SDC will monitor all reportable events to track and trend for misappropriation of funds through the Quality Assurance process monthly times 3, and then quarterly thereafter. Findings will be reported to the Quality Assurance committee for further review and recommendations.	9.27.2013



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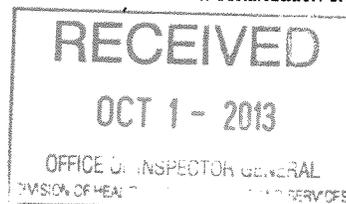
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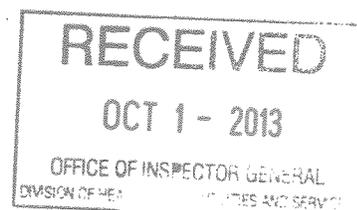
F 225	<p>Continued From page 2</p> <p>Investigations, revised 12/2011, revealed all reports or resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by the facility management. All suspected violations and all substantiated incidents of abuse would be immediately reported to appropriate state agencies and other entities or individuals as may be required by law.</p> <p>During interview, on 08/29/13 at 9:45 AM, with Resident #8 revealed he/she was missing twenty (20) dollars which was replaced by the facility. The resident also attended a Quality of Life group meeting, on 08/29/13 at 10:00 AM, and reported the missing money. The resident revealed the money came up missing between October 2012 and January 2013, but did not notify the facility until 08/22/13 during the care plan meeting.</p> <p>Review of the clinical record revealed the facility admitted Resident #8, on 10/02/13 with diagnoses of Acute Kidney Failure, and Alzheimer's Dementia. The facility assessed the resident on 08/14/13, utilizing the Minimum Data Set (MDS), Brief Interview for Mental Status (BIMS) that revealed a score of 15 indicating the resident was cognitively intact and had no behavioral or psychosocial concerns.</p> <p>On 08/29/13 at 12:45 PM, the Administrator reported the facility did not report the allegation to the OIG due to the elapsed time frame of the missing money.</p> <p>Further interview with the Administrator, on 08/29/13 at 4:18 PM, revealed the resident reported the missing money during the care plan meeting, which in turn was reported to her. The</p>	F 225		
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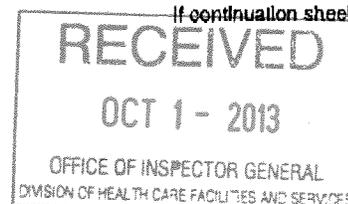
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F 225 F 425 SS=D	<p>Continued From page 3</p> <p>Administrator revealed it was determined the resident did have money, but they were unable to determine how much or when it disappeared due to the resident's condition at the time, and the time elapsed before it was reported. The Administrator revealed she initially did not think it was a reportable incident; however, in hindsight the Administrator felt the incident should have been reported to the OIG upon initial notification that the resident was missing money. The Administrator revealed she was aware of the requirement for reporting.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits; but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 225 F 425	<p>F 425: Expired medications of Unsampled Resident A and Unsampled Resident B were immediately removed from the refrigerator and destroyed per policy by the DON on 8.30.2013.</p> <p>Refrigerator was checked by DON/ADON on 8.30.2013, no other expired medications were found.</p> <p>All licensed nursing staff were in serviced by the SDC regarding facility policy related to the destruction of expired medications on 9.18.2013, 9.20.2013, and 9.21.2013.</p> <p>DON/ADON will randomly monitor refrigerator for any expired medications monthly times 3 months, and then quarterly thereafter.</p> <p>Findings will be reported to the Quality Assurance Committee for follow up and recommendations.</p>	9.27.2013



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F 425	<p>Continued From page 4</p> <p>by: Based on observation, record review, interview and facility policy review, it was determined the facility failed to remove narcotics from available stock for two (2) of three (3) unsampled residents and sixteen (16) sampled residents. Unsampled Resident A had three (3) vials of expired Ativan available in the refrigerator. Deceased Unsampled Resident B's Ativan remained in the refrigerator.</p> <p>The findings include:</p> <p>Review of the facility's policy for Controlled Substance, revised 12/2011, revealed when a resident was discharged from the facility, Scheduled II drugs could not be returned to the pharmacy, but must be destroyed in accordance with established policies. The policy statement indicated the facility shall comply with all laws, regulations and requirements related to the handling, storage, disposal and documentation of Schedule II and other controlled substances.</p> <p>Review of the facility's policy for Discarding and Destroying Medications, revised 12/2011, revealed medications that could not be returned to the dispensing pharmacy shall be destroyed.</p> <p>Observation during tour of the Medication Room with Licensed Practical Nurse (LPN) #1, on 08/30/13 at 7:43 AM, revealed three (3), 2 mg/ml vials of Lorazepam (Ativan), that expired 10/2012 with a pharmacy label, and identified for Unsampled Resident A remained accessible in the refrigerator. In addition, deceased Unsampled Resident B had Ativan 0.5 mg/ml concentrate, 28.5 ml that remained in the refrigerator.</p>	F 425			



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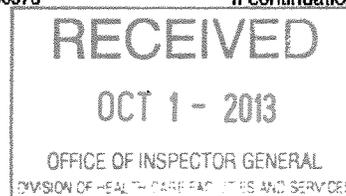
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F 425	<p>Continued From page 5</p> <p>Review of the Monthly Survey of the Medication Room Inspection, dated 12/12/12, as provided by the consulting pharmacy revealed the facility monthly controlled substance storage in section 3 did not identify Unsampld Resident A with outdated medications. The monthly survey of the medication room inspection, dated 02/19/13, revealed Unsampld Resident A was identified with Lorazepam (Ativan), expired on 10/2012. The medication room inspection, dated 04/16/13, revealed the facility monthly controlled substance storage in section 3, identified Unsampld Resident A with Lorazepam 2 mg/ml Injectable, expired 10/2012, three (3) vials. The monthly survey of the medication room, dated 06/14/13 and 08/15/13 did not identify the expired Lorazepam (Ativan). In addition, the monthly survey of the medication room, dated 08/15/13, did not identify deceased Unsampld B's narcotic medications remained accessible in the refrigerator thirty-one (31) days after he/she had expired.</p> <p>Clinical record review of Unsampld Resident A revealed the facility admitted the resident on 06/22/10 with diagnoses of Epilepsy, Dysphagia, Dementia without Behaviors, Impulse Control Disease and Symbolic Dysfunction.</p> <p>Clinical record review of Unsampld Resident B revealed the facility admitted the resident on 04/03/13 with diagnoses of Malignant Neoplasm of the Lung, Liver and Bone and Diabetes Mellitus II. The physician ordered Lorazepam (Ativan) on 07/14/13 for anxiety. Upon clinical record review, Unsampld Resident B passed away on 07/15/13, forty six (46) days prior.</p>	F 425		

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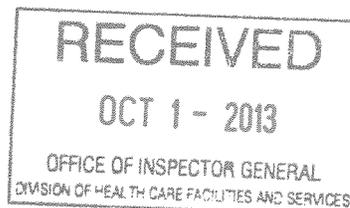
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F 425	<p>Continued From page 6</p> <p>Interview with LPN #1 during tour of the medication room, on 08/30/13 at 7:43 AM, revealed they count the narcotics with each shift change. She reported the routine medication are returned to the pharmacy and the narcotics are given to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) for disposal. She did report, once a resident was discharged, then the medication are pulled and sent back to the pharmacy or the DON was notified about the narcotics.</p> <p>Interview with the ADON, on 08/30/13 at 8:25 AM, revealed the expired medications were picked up by the pharmacy and the narcotics were destroyed by the ADON and the DON by putting them in an undesirable substance. She reported the consulting pharmacist did a monthly inspection report of the medication room. She reported only the narcotics are disposed of by the facility. She stated the expired medications should have been removed. She was not aware expired medications remained in the cabinet. However, the pharmacy did provide a monthly inspection report.</p> <p>Interview with the DON, on 08/30/13 at 8:30 AM, revealed the expired and discontinued narcotic medications are disposed of by the facility. The pharmacy did not accept the narcotics. She reported the expired medication should be removed when expired for disposal. She denied being aware the expired medication remained in the refrigerator ten (10) months past expiration and the deceased resident's medications remained in stock forty six (46) days.</p>	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F 441: See p. 8.	



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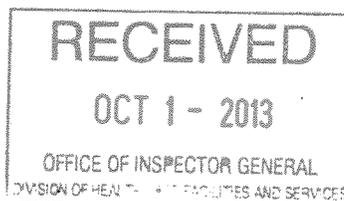
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F 441	Continued From page 7 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and Infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as Isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs Isolation to prevent the spread of infection, the facility must Isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F 441: Licensed Practical Nurse #2, Licensed Practical Nurse #3 and Certified Nursing Assistant #2 were re educated to Infection Control guidelines that included hand washing and use of gloves by SDC on 9.1.2013, 9.9.2013 and 9.20.2013. Residents #1, #3, and #9 were assessed by licensed nurses on 9.18.2013, 9.19.2013 and 9.23.2013 with no signs of infection noted. All residents residing in the center benefit from proper hand washing procedures and the use of gloves. The SDC re educated all the nursing staff on hand hygiene and use of gloves on 9.1.2013 through 9.24.2013. Any concerns were addressed immediately. SDC will complete observations of a minimum of 2 licensed nurses and 2 certified nursing assistants during meal times and resident care to determine that hand washing procedures and use of gloves are per policy weekly times 8 weeks, then monthly times 1 month, and then quarterly thereafter. These findings will be submitted to Quality Assurance Committee quarterly times 3 for further review and recommendations.	9.27.2013



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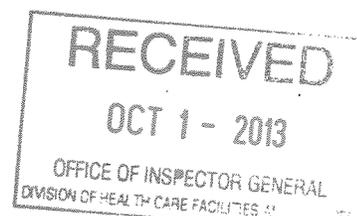
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F 441	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and review of the facility policies, it was determined the facility failed to practice appropriate hand hygiene for two (2) of the sixteen (16) sampled and one (1) of three (3) unsampled residents (Residents #3, #9 and Unsampled Resident C). Staff failed to wash their hands between glove changes during the individual medication pass for Resident #9 and Unsampled Resident C. Staff failed to wash their hands between glove changes during Resident #3's catheter care.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Personal Protective Equipment-Using Gloves, revised 12/2011, revealed an objective to using gloves was to prevent the spread of infection. In addition hands were to be washed after removing gloves.</p> <p>Review of the facility's policy titled Personal Protective Equipment-Gloves, revised 12/2011, revealed hands were to be washed after removing gloves.</p> <p>Review of the facility's policy regarding Handwashing/Hand Hygiene, reviewed 12/2011, revealed hands were to be washed after removing gloves.</p> <p>1. Observation, on 08/29/13 at 7:42 AM, during the medication pass for Unsampled Resident C revealed Licensed Practical Nurse (LPN) #2 put on gloves, removed the dressing from around the gastrostomy tube (g-tube) site, cleansed around the site and placed a dressing back over the g-tube site. LPN #2 then removed her gloves, put</p>	F 441		



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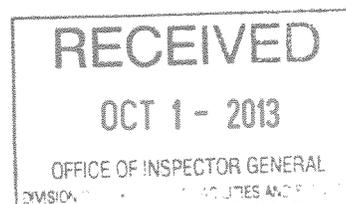
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F 441	<p>Continued From page 9</p> <p>on another pair of gloves without washing her hands and administered the medications to Unsampled Resident C via g-tube.</p> <p>Observation, on 08/29/13 at 8:27 AM, during the medication pass for Resident #9 revealed LPN #3 put on gloves to administer oral medications. LPN #3 then removed her gloves and put on another set of gloves to administer eye drops to Resident #9. LPN #3 did not wash her hands between the changing of gloves.</p> <p>Interview, on 08/30/13 at 1:15 PM, with Licensed Practical Nurse (LPN) #2 revealed she put on gloves to clean the gastrostomy site of Unsampled Resident C then changed the gloves to administer the medications down the g-tube. She stated she then washed her hands when she completed the medications. LPN #2 stated she was not aware she needed to wash her hands between glove change. She stated she had been in-serviced on hand hygiene; however, she did not wash her hands between the glove change for Unsampled Resident C.</p> <p>Interview, on 08/30/13 at 1:28 PM, with the Assistant Director of Nursing (ADON) revealed hands were to be washed between glove change. She stated she had been in-serviced on hand hygiene and the reason to wash your hands between glove change was to prevent the spread of infection.</p> <p>Interview, on 08/30/13 at 1:40 PM, with the In-Service Coordinator revealed the staff had been in-serviced on washing their hands when they changed gloves. He stated hand hygiene was important to prevent infection. He revealed you would not want to grab a dirty glove with a</p>	F 441		



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

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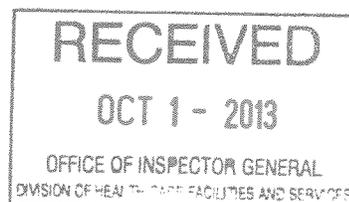
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701		
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F 441	<p>Continued From page 10</p> <p>clean hand, as you would when removing the second glove worn, and not wash your hands. He stated hand washing prevented cross contamination between residents.</p> <p>Interview, on 08/30/13 at 4:00 PM, with the Director of Nursing (DON) revealed when gloves were changed or removed, hands were to be washed. She revealed if you changed gloves during a procedure it was because you were going from an unclean area to a clean area which would have you wash your hands. She stated the staff had been in-serviced on hand washing and glove changes. The DON stated the importance of hand hygiene was to protect the residents and staff and to prevent the spread of infections.</p> <p>2. Observation of indwelling catheter care provided to Resident #3, on 08/30/13 at 11:03 AM, revealed Licensed Practical Nurse (LPN) #1 and Certified Nurse Aide (CNA) #2 wore gloves as they assisted him/her to bed in preparation for catheter care. Upon the resident's return to his/her bed, LPN #1 removed her gloves and reapplied a pair of gloves. She did not completed hand hygiene between glove change. She changed her gloves a total of six (6) times before, during and after catheter care. She returned the wash basin to the bathroom. She placed soiled linens in a plastic bag without hand hygiene before she put on the next pair of gloves. Each time the gloves were removed, hand hygiene was not completed prior to the next pair of donned gloves.</p> <p>Interview with LPN #1, on 08/30/13 at 2:55 PM, revealed hand hygiene was to be done to prevent cross contamination and spreading of germs during patient care. She reported hand washing</p>	F 441		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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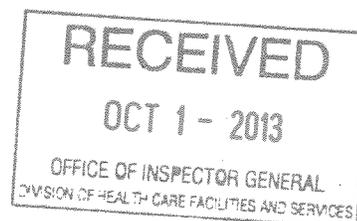
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F 441	Continued From page 11 or the use of gel should always be used before the application of gloves and when changing gloves. She reported, she only did hand gel after she was completed with the care of the resident when finished with the indwelling catheter care. She reported, she just did not think about doing the hand hygiene between glove change since it was the same patient.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's Medical Record Audit tool and the facility's policies titled Do Not Resuscitate Order and Advanced Directives, it was determined the facility failed to maintain an accurate medical record for one (1) of sixteen (16) sampled residents, Resident #1. The facility staff failed to obtain authorization from Resident #1 or his/her legal guardian before obtaining a physician's Do Not Resuscitate (DNR) order. The facility staff	F 514	F 514: Resident #1's medical record was reviewed and DNR status was updated on 8.30.2013 by DON. Orders were also checked to ensure that they were signed and dated. DON/ADON audited all other current residents' medical records on 9.3.2013; no other records/residents were affected. SDC in serviced all nursing staff regarding DNR status and signing and dating orders on 9.1.2013 through 9.11.2013. DON/ADON/Medical Records Coordinator will randomly monitor 8 charts per month times 3 months, and then quarterly thereafter, to ensure that medical record is accurate. Findings will be reported to Quality Assurance Committee for further review and recommendations.	9.27.2013



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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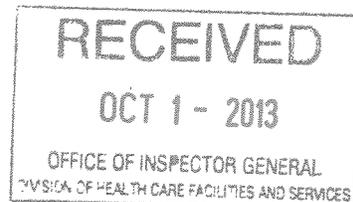
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F 514	<p>Continued From page 12</p> <p>further failed to ensure all orders were dated when Increasing a dose of medication for Resident #1.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Do Not Resuscitate Order, Revised May 2013, revealed a DNR form must be completed and signed by the resident or the resident's legal representative/surrogate and placed with the advanced directives in the resident's medical record.</p> <p>Review of the facility's policy titled Advance Directives, Revised May 2013, revealed Do Not Resuscitate was defined as a written order that the resident, legal guardian, health care proxy, or representative had directed the authorizing medical personnel to withhold cardiopulmonary resuscitation (CPR) including artificial resuscitation and defibrillation, in case of respiratory or cardiac failure.</p> <p>Review of the facility's Medical Record Audit Tool, facility Form 1136P, undated, revealed It was the responsibility of the Medical Records department to ensure the completeness of the medical record by reviewing the different areas included in the chart. Areas of the medical record review included: Advanced directives, Advance directive acknowledgment, Code Status and Physician's orders verified by a nurse.</p> <p>Review of the medical record for Resident #1 revealed no authorization for a DNR order by the resident or the resident's legal representative. However, the record had a Physician's Order signed and dated 08/20/13 which contained the</p>	F 514			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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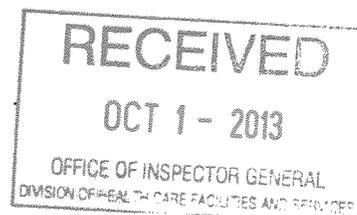
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F 514	<p>Continued From page 13</p> <p>order "DNR" for Resident #1. In addition, the record contained a telephone order to increase the oral potassium Resident #1 was taking to 20 milliequivalents (mEq) daily. The order was undated. The signed Physician's order, dated 08/20/13, revealed an order for Potassium 10 mEq by mouth every day. The Medication Administration Record (MAR) listed the dose as 20 mEq by mouth every day during the medication observation on 08/29/13.</p> <p>Interview, on 08/29/13 at 11:30 AM, with the Director of Nursing (DON) revealed the chart of Resident #1 contained an order for DNR and no documented authorization for the order. She revealed there were some family dynamics which had prevented the facility from receiving the authorization for the DNR order. She revealed she understood the process for a resident to be designated as DNR and the importance of having the correct designation on the resident's chart.</p> <p>Interview, on 08/30/13 at 8:30 AM, with Medical Records revealed the resident's chart was audited using the Medical Record Audit Tool. She revealed there was not a DNR order for Resident #1. She revealed the nurses were responsible to review the monthly Physician's orders for accuracy. Continued interview revealed Medical Records was responsible to ensure orders were signed and dated. She stated she had reviewed with the nursing staff the process to sign and date verbal and/or telephone orders.</p> <p>Interview, on 08/30/13 at 2:03 PM, with the Minimum Data Set (MDS) Nurse revealed the first indication a resident was a DNR was the green DNR sheet in the chart. She revealed, if a green sheet was present not in the chart when she</p>	F 514		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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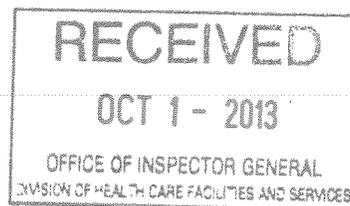
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F 514	<p>Continued From page 14</p> <p>looked, she would perform CPR on the resident if indicated. There was no green sheet in the chart of Resident #1. She revealed the importance of knowing the code status of a resident was so the wishes of the resident would be honored.</p> <p>Interview, on 08/30/13 at 2:45 PM, with Licensed Practical Nurse (LPN) #2 revealed the code status of a resident may be found on the nurse report sheet or as a purple dot on the side of a resident's chart or from the signed form on a green sheet in the chart noting the resident was a DNR. Continued interview revealed it was standard nursing practice to sign and date a physician's order when received. She stated the importance of a dated order was for accuracy and record keeping, and to know when the order was received.</p> <p>Interview, on 08/30/13 at 1:40 PM, with the In-Service Coordinator revealed the nursing staff had been in-serviced on Physician's Orders. However, the DNR physician order had not been reviewed for Resident #1 and remained on the current orders signed and dated 08/20/13. In addition, the In-Service Coordinator stated it was "sloppy nursing" to not sign and date a physician telephone/verbal order because it was standard nursing practice. He revealed it was important to sign and date physician orders because you need to know when the order was taken and it also validated the order.</p>	F 514			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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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: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Ground Floor and a Basement, Type III (200)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with forty four (44) heat and six (6) smoke detectors</p> <p>SPRINKLER SYSTEM: Complete, automatic, wet sprinkler system.</p> <p>GENERATOR: Type II generator installed in 1986. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 09/05/13. Helmwood Healthcare Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</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>Preparation and execution of this plan of correction does not constitute admission or agreement of any alleged deficiencies cited in the 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>	



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

X [Signature]

TITLE

X Executive Director

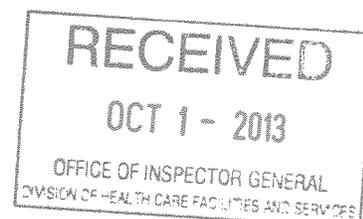
(X6) DATE

10/1/13

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

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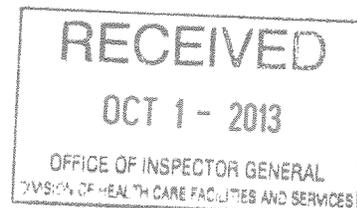
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K 000 K 025 SS=E	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD Is not met as evidenced by: Based on observations and Interview, It was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of six (6) smoke compartments, thirty nine (39) residents, staff and visitors. The facility is certified for sixty (60) beds, with a census of fifty seven (57) on the day of the survey. The facility failed to ensure smoke partitions were sealed to resist the passage of smoke. The findings include: Observation, on 09/05/13 at 10:25 AM, with the Environmental Services Director revealed the	K 000 K 025	K 025: Smoke partitions extending above the ceiling located in the North Hall, West Hall and in the basement over the speech room were sealed by the Maintenance Supervisor with appropriate related material on 10.18.2013 to resist the passage of smoke. Smoke partitions in the North and West Halls were sealed to the metal corrugated decking that separates the attic space from the space below on 10.18.2013. A review was conducted by the Maintenance Supervisor on 9.19.2013 to determine that no other opening exists in the smoke wall barriers. There were no additional penetrations to the smoke barriers/partitions identified. Re education was provided to Environmental Services Supervisor and Maintenance Supervisor on 9.18.2013 by the ED regarding maintaining smoke barriers and partitions in accordance with NFPA standards. The Maintenance Supervisor will check smoke barrier walls and partitions monthly times 2, then every 6 months, to validate that smoke barrier walls and partitions have no penetrations and are sealed with fire resistant materials as needed. The	



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K 025	Continued From page 2 smoke partitions extending above the ceiling located in the North Hall, West Hall, and in the basement over the Speech Room had penetrations of pipes and wires that were not sealed to resist the passage of smoke. Further observation revealed the smoke partilons located in the North Hall and the West Hall were not completely sealed to the metal corrugated decking that separated the attic space from the space below. Interview, on 09/05/13 at 10:25 AM, with the Environmental Services Director revealed she was not aware the smoke partitions were not sealed properly. Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar	K 025	(continued from p. 2) results of these audits will be reviewed by the QA committtee quarterly for further review and recommendations.	10.18.2013



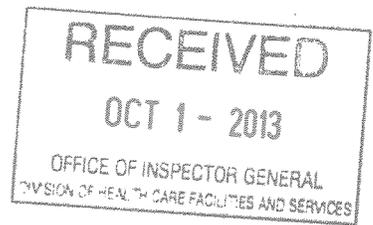
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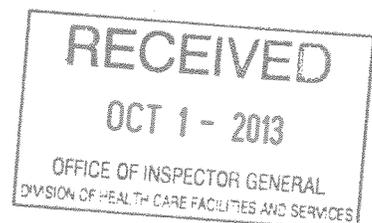
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K 025	<p>Continued From page 3</p> <p>building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <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> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. <p>19.3.7.4 Not less than 30 net ft² (2.8 net m²) per patient in a hospital or nursing home, or not less than 15 net ft² (1.4 net m²) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. On stories not housing bed or litterborne patients, not less than 6 net ft² (0.56 net m²) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments.</p> <p>19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel</p>	K 025		



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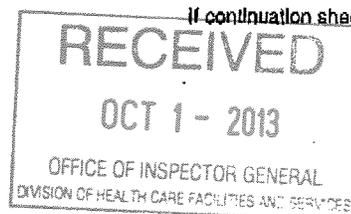
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 4 frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.	K 025		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation, and interview it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty six (57) on the day of the survey. The facility failed to test emergency battery lighting for 90 minutes annually. The findings include: Observation, on 09/05/13 at 11:50 AM, with the Environmental Services Director revealed the facility did not have documentation for the annual testing of emergency battery lighting located in the facility. Interview, on 09/05/13 at 11:50 AM, with the Environmental Services Director revealed they	K 046	K 046: Testing for the emergency battery lighting was completed on 9.17.2013 by the Maintenance Supervisor. The Maintenance Supervisor tested center emergency lighting, no battery failure was identified. Environmental Services Supervisor and Maintenance Supervisor were re educated by the Executive Director on 9.18.2013 on testing emergency lighting in accordance with NFPA standards. Maintenance Supervisor will test emergency battery lighting for 30 seconds monthly and 90 minutes annually. The emergency battery lighting test results will be discussed by Quality Assurance Committee quarterly for further review and recommendations.	10.18.2013



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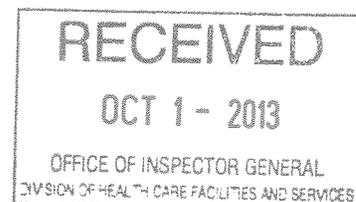
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K 046	Continued From page 5 were not aware documentatlon was to be kept for emergency battery light testing. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency Illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual	K 046		



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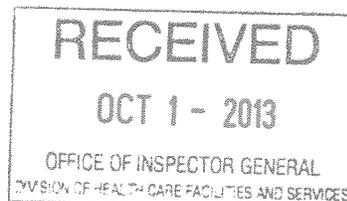
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K 046 K 050 SS=F	Continued From page 6 inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware 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 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty seven (57) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly at unexpected times. The findings include: Fire Drill record review, on 09/05/13 at 11:44 AM, with Environmental Services Director revealed the facility failed to conduct fire drills at unexpected times under varied conditions on third shift.	K 046 K 050	K 050: Fire drill was conducted on the third shift at 4:30 am on 9.19.2013 by Maintenance Department. Environmental Services Supervisor and Executive Director revised the fire drill schedule for the remainder of the calendar year on 9.17.2013 to ensure drills are conducted on each shift and under varied conditions and at unexpected times at least quarterly. Environmental Services Supervisor and Maintenance Department were re-educated by the Executive Director on 9.18.2013 regarding conducting fire drills at least quarterly on each shift and at unexpected times in accordance with NFPA standards. The Environmental Services Supervisor will record dates and times of fire drills conducted each month and bring to Quality Assurance meeting quarterly for review and further recommendations.	10.18.2013



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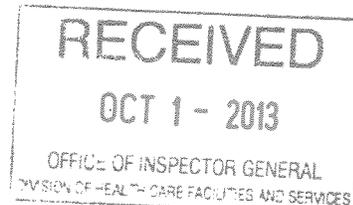
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K 050	Continued From page 7 Interview, on 09/05/13 at 11:44 AM, with the Environmental Services Director revealed she was unaware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care 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)	K 050			



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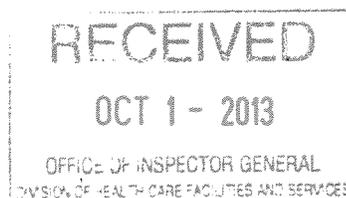
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K 050	Continued From page 8 with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible 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.	K 050		
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 installed, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty seven (57) on the day of the survey. The facility failed to ensure the	K 056	K 056: The obstructed sprinkler heads located in the kitchen were replaced on 9.25.2013. No other light fixtures were found to be installed within 12 inches of a sprinkler head, extending below the deflector of the sprinkler head, and obstructing the sprinkler from developing a full pattern. Re education was provided to ESS and Maintenance Supervisor on 9.18.2013 by the ED regarding the placement of light fixtures which can obstruct the sprinkler from developing a full pattern. The Maintenance Supervisor will monitor the placement of light fixtures in relation to sprinkler head placement monthly times 2, and then quarterly. Results will be monitored by the QA Committee for review and further recommendations.	10.18.2013



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 056	<p>Continued From page 9 facility had complete sprinkler coverage.</p> <p>The findings include:</p> <p>Observation, on 09/05/13 at 12:45 PM, with the Environmental Services Director revealed light fixtures installed within twelve (12) inches of a sprinkler head, extending below the deflector of the sprinkler head and obstructing the sprinkler from developing a full pattern. The obstructed sprinkler heads are located in the Kitchen.</p> <p>Interview, on 09/05/13 at 12:45 PM, with the Environmental Services Director revealed the light fixtures in the Kitchen had been replaced a few years ago.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises</p>	K 056		



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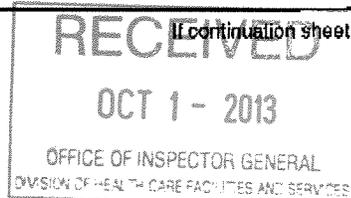
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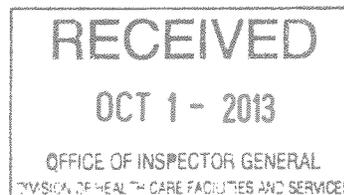
K 056	<p>Continued From page 10</p> <p>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</p> <p>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th style="text-align: left;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th style="text-align: left;">Maximum Allowable Distance of Deflector Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.)</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)																									
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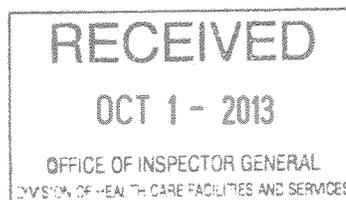
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K 056	Continued From page 11 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty seven (57) on the day of the survey.	K 062	K 062: The sprinkler system had the gauges on the risers calibrated and/or replaced as needed on 9.25.13 by Kelly Fire Protection Inc. Documentation will be maintained by ESS that sprinkler system had gauges on risers calibrated or replaced every 5 years. (5-year inspection completed on 9.25.2013.) Re education was provided to ESS and Maintenance Department on 9.18.2013 by the ED regarding the calibration of the gauges on the risers and/or replacement for the sprinkler system every 5 years. The ESS will monitor documentation for the calibration or replacement of the sprinkler riser gauges every month times 2 and then quarterly times 2. Findings will be	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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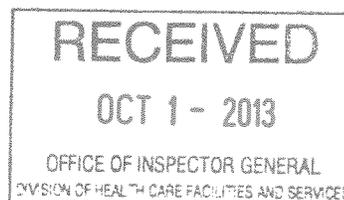
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K 062	Continued From page 12 The findings include: Sprinkler testing record review, on 09/05/13 at 10:40 AM, with the Environmental Services Director revealed the facility did not have documentation that the sprinkler system had the gauges on the risers calibrated or replaced within the last five (5) years. Interview, on 09/05/13 at 10:40 AM, with the Environmental Services Director revealed she was not aware the facility was required to have documentation for the calibration or replacement of the sprinkler riser gauges. Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2	K 062	(continued from p. 12) reviewed by the QA Committee for further recommendations.	10.18.2013



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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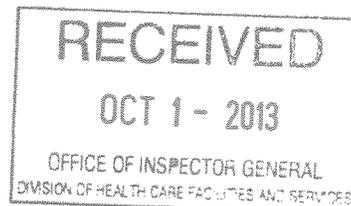
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K 062	Continued From page 13 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062	
K 144 SS=F	NFFA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFFA 99. 3.4.4.1.	K 144	K 144: See p. 15.



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

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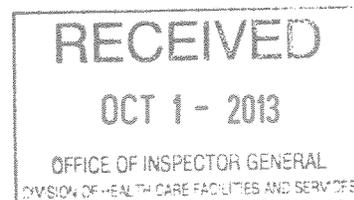
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 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 144	Continued From page 14 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for sixty (60) beds with a census of fifty seven (57) on the day of the survey. The findings include: Observation, on 09/05/13 at 11:52 AM, with the Environmental Services Director revealed the facility did not have documentation for the transfer times, on the monthly generator testing. Interview, on 09/05/13 at 11:52 AM, with the Environmental Services Director revealed she was not aware the transfer times were to be documented. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the	K 144	K 144: An emergency power generator test was completed on 9.19.13 by the Maintenance Supervisor. The start time of the test was 9 am and end time was 9:45 am; the transfer to emergency power was 2 (two) seconds. The generator was determined to be functioning properly. The Maintenance Supervisor documented transfer time in a numeric figure. Re education was provided to the Environmental Service Supervisor and the Maintenance Supervisor on 9.18.2013 by the Executive Director regarding recording the transfer time in a numeric figure to ensure that the emergency generator is maintained in accordance with NFPA standards. The Environmental Services Supervisor and Maintenance Supervisor will document generator transfer times in numeric form during each monthly emergency power generator test. The Environmental Services Supervisor will monitor documentation of generator transfer times every month times 2, and then quarterly thereafter. This documentation will be reviewed by the Quality Assurance Committee for further recommendations	10.18.2013



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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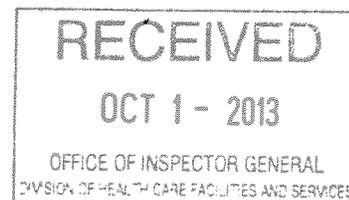
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K 144	<p>Continued From page 15</p> <p>generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.)</p> <p>The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]</p> <p>Reference: NFPA 110 (1999 Edition).</p>	K 144		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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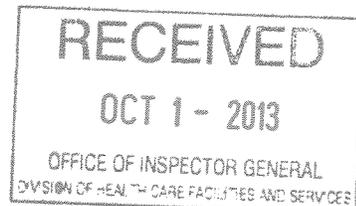
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701	
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K 144	<p>Continued From page 16</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>Reference: NFPA 99 (1999 Edition)</p> <p>Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).</p> <p>Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source</p>	K 144		



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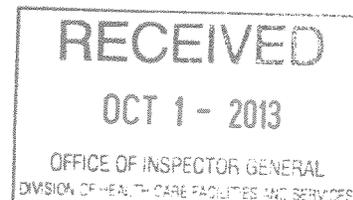
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2013
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K 144	<p>Continued From page 17</p> <p>and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p>	K 144		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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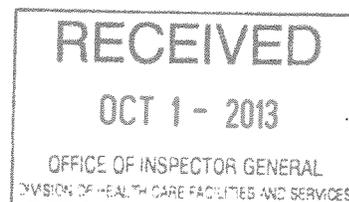
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K 144	<p>Continued From page 18</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. Reference: NFPA 110 (1999 ed.)</p> <p>5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly</p>	K 144	



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

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K 144	Continued From page 19 sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter, uninsulated or insulated exhaust pipes, and other heat-producing equipment. 5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related accessory equipment that exceed the recommendations of the manufacturer. 5-7.3 For the EPS equipment room, the ventilation or cooling equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer ' s criteria or allowable maximum temperatures. Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building	K 144			



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

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K 144	<p>Continued From page 20 codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p>	K 144		

