

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

PRINTED: 11/19/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166163 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/01/2012 |
| 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 A standard health survey was conducted on 10/29/12 through 11/01/12 and a Life Safety Code survey was conducted on 10/30/12 with deficiencies cited at the highest scope and severity at an "E". The facility had the opportunity to correct the deficiencies before imposition of remedies would be recommended. | F 000 | | |
| F 160 SS-B | 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to convey resident trust funds for two (2) of five (5) closed accounts within the required 30 days. The findings include: There was no policy provided during the survey regarding conveyance of funds from residents' trust funds accounts. Review of five (5) deceased resident's trust funds accounts which were completed, on 11/01/12 at 4:00 PM, revealed two (2) of five (5) resident's accounts had not been dispersed within the 30 days of the resident's deceased date. | F 160 | "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." 1) Resident #3's date of death was 2/28/12. Funds were conveyed to the resident's estate 04/24/12. Resident #4's date was 02/20/12 and funds were conveyed to the resident's estate 04/24/12. 2) Identification of other potential: Records of all other deceased residents since the last state survey were reviewed to insure timeliness of disbursement regarding conveyance of resident's funds upon death. The audit was completed on 11/2/12 and revealed no further residents affected. 3) The Executive Assistant will complete an audit every month to insure timeliness of disbursement regarding conveyance of resident's funds upon death. 4) The Executive Assistant role is assigned the responsibility to review a resident trust summary monthly to insure funds are conveyed within 30 days of the death of every resident. | 11/3/12 |

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

TITLE

(X6) DATE

X [Signature]

X Executive Director X 11/29/12

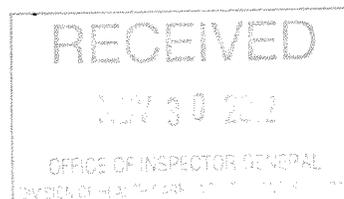
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

OFFICE OF
DIRECTOR

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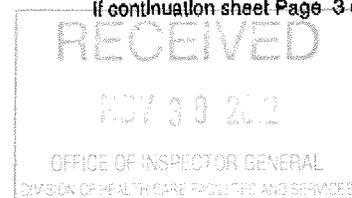
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185183 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/01/2012 |
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| F 160 | Continued From page 1 Unsampled Resident #3 had expired, on 02/28/12, however, the date of conveyance was 04/24/12. Unsampled Resident #4 had an expiration date of 02/20/12, however, the funds were not conveyed until 04/24/12. Interview with the facility Accountant responsible for Resident Trust Funds, on 11/01/12 at 4:16 PM, revealed all funds should be conveyed within 30 days; and the corporate office was responsible for dispersment of all funds. The Accountant stated she notified the corporate office, who revealed both resident's families donated the money to the facility, and the time span for sending out the request form, and getting the form back, took over the 30 day time frames. Interview with the Administrator, on 11/01/12 at 4:45 PM, revealed the facility should have conveyed the funds within the 30 days, according to the regulation, whether or not the money had been donated to the facility. | F 160 | 5) A report of resident fund distribution will be reported directly to the Executive Director no less than every 30 days with on-going monitoring for trends being reviewed in QA meeting monthly for twelve consecutive months. Additional follow up and/or in-services needs will follow as needs are identified based on QA outcomes. | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. | F 279 | "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." | 11/5/12 |



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| F 279 | <p>Continued From page 2</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to develop a behavior care plan for one (1) of fourteen (14) sampled residents, Resident #6.</p> <p>The findings include:</p> <p>Review of the Care Planning - Interdisciplinary Team policy, reviewed December 2011, revealed the facility's care planning/interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident was developed within seven (7) days of completion of the resident assessment Minimum Data Set (MDS).</p> <p>Record review of Resident #6's care plan revealed no care plan noted for behaviors.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 10/31/12 2:29 PM, revealed staff documented on the Behavior sheets for the MDS assessment, seven (7) days for behavior and fourteen (14)</p> | F 279 | <p>1) The care plan for resident #6 was reviewed by the MDS Nurse and revised on 11/5/12 to include behaviors and non pharmacological interventions used prior to the administration of the antipsychotic.</p> <p>2) The MDS Nurse reviewed care plans of residents who experience behaviors to ensure that appropriate care plans were in place with non pharmacological interventions used prior to administration of the antipsychotic are included. This was completed 11/1/12.</p> <p>3) RN's and LPN's were in-serviced by the Director of Nursing in preference for using and documenting non-pharmacologic interventions related to behaviors. This completed by the Director of Nursing on 11/2/12.</p> <p>4) The Interdisciplinary Team was provided reeducation by the Director of Nursing on 11/1/12 regarding the need for the care plan to address residents who have diagnosis of experience behaviors and include non pharmacological interventions. Care plans of residents who have diagnosis and/or experiencing behaviors will be updated by the MDS nurse at the time of the physician order. The MDS nurse will review care plans with assessment schedule with corrective action if indicated. Findings will be reviewed with the Director of Nursing and Executive Director.</p> <p>5) Trends identified will be reviewed at the monthly Quality Assurance Committee for any additional follow up and/or in-services needs.</p> | | |



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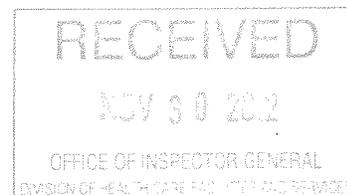
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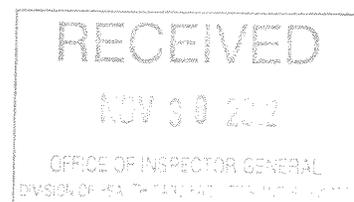
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| F 279 | <p>Continued From page 3 days for mood.</p> <p>Review of Resident #6's clinical record revealed the facility admitted the resident with Anxiety, Depression and Dementia on 09/25/12. Review of the nursing notes for the dates of 09/25/12 through 10/02/12 revealed on 09/26/12 at 11:52 PM, Allan was given for increased anxiety. On 09/30/12 at 8:15 PM, Resident #6 became very agitated with staff. Upon redirection resident became verbally abusive with staff and threatening. On 10/01/12 at 3:22 PM, staff was ambulating resident up and down hallway several times due to Resident #6 getting anxious and wanting to go home. Allan received after talking to and calming resident enough to get him/her to take medication. 10/01/12 at 12:00 AM, revealed Resident #6 was very confused and had difficulty redirecting. Resident #6 could not understand where her bed was and kept coming into the hallway without his/her wheelchair or walker. Staff attempted to redirect Resident #6 without success.</p> <p>Interview with LPN #2, on 11/01/12 10:02 AM, revealed Nursing staff did initiate the admission care plan, but the MDS staff was responsible for the assessment care plans, updating and initiating any additional care plans.</p> <p>Interview with the MDS Coordinator, on 11/01/12 1:17 PM, revealed the Behavior log was a tool the Social Services used to do the BIM score. The MDS Coordinator stated she looked at the nurse's notes and behavior sheets that were used by Social Services because Social Services completed the behavior part of the MDS. The MDS Coordinator stated she was responsible to</p> | F 279 | | |
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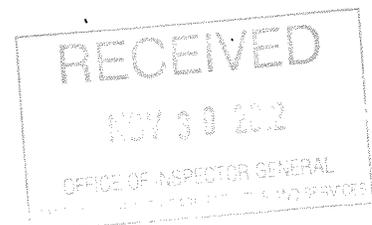
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| F 279 | Continued From page 4 complete the care plan on Behavior, If it was triggered on the CAA. If the behavior was not triggered on the CAA, then the nursing staff would have to initiate the care plan on behavior. When the MDS Coordinator was asked how did the nurses know the plan of care for Resident #6 If there was not care plan, the MDS Coordinator stated then the nurses would have to use their nursing judgment. Interview with the Director of Nursing (DON), on 11/01/12 2:47 PM, revealed she looked at care plans and updated the care plans as needed. The DON stated she was thinking about letting administration put the Interventions on the care plans. The Behavior care plan should show interventions used before administering any medications. If there was no care plan, then the nurses would not know what to do for the resident. Behavior sheets were pulled by the MDS when they were doing the residents assessments. The MDS Coordinator should have completed a behavior care plan. The DON further stated there should have been a behavior care plan for Resident #6's behavior. | F 279 | | |
| F 309 SS=D | 403.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F 309 | "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." | 11/21/12 |



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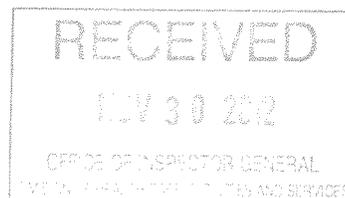
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| F 309 | <p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observallon, interview and record review it was determined the facility failed to implement physician orders for one (1) of fourteen (14) sampled residents, Resident #6. The facility staff failed to apply Resident #6's alarm as ordered on 10/31/12 and 11/01/12.</p> <p>The findings include:</p> <p>No policy was provided by the facility on following physician orders.</p> <p>Review of Resident #6's clinical record revealed the facility admitted the resident on 09/25/12 with diagnoses of a History of a Fracture, Difficulty Walking, Anxiety, Dementia, Osteoarthritis, Muscle Weakness, Malaise and Fatigue and Joint Replacement of the Hip. Review of the Physician Orders, dated 10/30/12, revealed a new order for a chair alarm due to the fact the resident sustained a fall earlier that evening.</p> <p>Observallons made in the Rehab Department, on 10/31/12 at 11:10 AM, revealed Resident #6 sitting in his/her wheelchair with no chair alarm attached. Observallon made on, 11/1/12 at 11:30 AM, revealed Resident #6 sitting at the nurses' station in a wheelchair with no alarm attached to the chair.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 10/31/12 at 2:35 PM, revealed she was not aware Resident #6 was to wear a chair alarm and usually the nurses inform them when a change occurs in the residents care.</p> | F 309 | <p>1) Resident #6 alarm was placed on by the nursing staff and double checked by the Director of Nursing on 11/1/12. Care plan was checked on 11/1/12 to make sure alarm was appropriately care planned.</p> <p>2) Facility will identify other residents having the potential to be affected by the same deficient practice by an immediate audit of all alarm orders to assure that every alarm is listed on the resident's care plan. Assistant Director of Nursing and Director of Nursing will audit care plans and assure that all physician ordered alarms are care-planned appropriately were completed on 11/20/12.</p> <p>3) Facility will put the following measures in place to assure the deficient practice will not recur. Restorative nursing will pull all alarm orders weekly and utilize this information to complete weekly rounds to ensure all residents with orders have alarms in place according to physician orders. All nursing staff will be reeducated on location of pertinent care information, including alarms for residents. The nurses will check and sign off on TAR each shift that alarms orders and in working order with a battery check every Sunday for every alarm prior to nurse signing off TAR.</p> <p>4) Restorative weekly alarm audits will be analyzed with trends identified and reviewed for twelve months at the monthly Quality Assurance Committee for any additional follow up and/or in-services needs.</p> | | |



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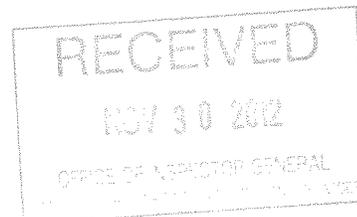
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| F 309 | Continued From page 6 Interview with Licensed Practical Nurse (LPN) #2, on 11/01/12 at 10:02 AM, revealed she was not aware resident #6 was not wearing his/her chair alarm. LPN #2 stated she was not aware the CNA's were not informed of the alarm status for Resident #6. LPN #2 finally stated the chair alarm was placed to resident #6's chair to prevent falls from occurring. Nurses were responsible to inform the CNA's of changes to orders. Interview with the Director of Nursing (DON), on 11/01/12 at 2:47 PM, revealed Resident #6 did not have his/her alarm attached to his/her wheelchair during the lunch hour and that the alarm should have had been attached to the wheelchair. The DON further stated it was the staff 's responsibility to follow the orders given by the physician and ultimately her responsibility to ensure staff were doing what they were suppose to do. | F 309 | | |
| F 329 SS=D | 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition | F 329 | "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." 1) On 11/1/12, the Director of Nursing reviewed with the pharmacists the need for dose reduction for resident #7. A dose reduction was ordered and monitored. No adverse effects noted, therefore Seroquel was discontinued on 11/5/12 by the physician. | 11/7/12 |



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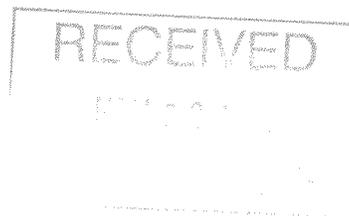
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| F 329 | <p>Continued From page 7</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure one (1) of fourteen (14) sampled residents were free from unnecessary drugs. Resident #7 was placed on an antipsychotic medication without a gradual dose reduction attempted for over a year and no documented evidence why a reduction may be contraindicated. The record revealed the resident exhibited no behaviors that would indicate the use of the antipsychotic medication.</p> <p>The findings include:</p> <p>A facility policy related to behaviors and the use of antipsychotic medications was requested during the survey; however, the facility failed to provide a specific policy.</p> <p>Review of the clinical record revealed Resident #7 had resided at the facility since June 2009. Continued review of the clinical record revealed the resident was receiving an antipsychotic medication (Seroquel) upon admission. Review of the diagnoses list revealed Resident #7's</p> | F 329 | <p>2) An audit was completed by the Director of Nursing for every resident currently on an antipsychotic medication. Diagnoses and GDR requests were reviewed for most recent dates requested as well as physician response.</p> <p>3) The SDC nurse re-in serviced the nurses on 11/1/12, 11/5/12, and 11/6/12 on the need for justification to support that the increase of antipsychotic medication is documented in the nurses notes, behavior monitoring sheets, or other clinical rationale before an antipsychotic medication is increased or ordered initially. Residents who have orders for antipsychotic medication will be reviewed in the monthly behavior meeting by the Director of Nursing no less than quarterly to evaluate behavioral needs for the medication and/or appropriateness of a GDR attempt. Additionally, Director of Nursing will review monthly pharmacy GDR request for appropriate physician responses including rationale if GDR is declined. Director of Nursing will contact physician if rationale not provided. If physician does not respond within timely manner the Director of Nursing will contact Medical Director. The Medical Director will then review the resident's drug regimen and speak to the physician about a GRD if needed.</p> <p>4) Trends identified in Behavior meeting and GDR audit will be reviewed for twelve months at the monthly for Quality Assurance Committee for any additional follow up and/or in-services needs.</p> | |



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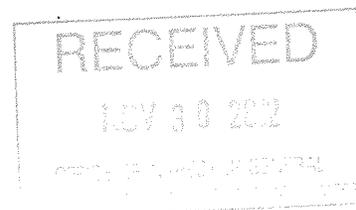
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| NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 108 DIECKS DRIVE ELIZABETHTOWN, KY 42701 | |
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| F 329 | Continued From page 8 physician had diagnosed the resident to have Alzheimer's Disease and Dementia with behavioral disturbances. The clinical record revealed a gradual dose reduction was conducted on 09/30/11 that decreased the Seroquel dose from 50 mg to 25 mg. Review of the most current physician orders for October 2012 revealed the resident was currently receiving Seroquel 25 mg every morning and evening for a total of 50 mg per day. Review of a pharmacy drug regimen consultation report, dated 03/30/12, revealed the pharmacist requested the physician to assess the use of Seroquel related to a Dementia diagnosis. The pharmacist documented the rationale for the recommendation as following: the Food and Drug Administration (FDA) has released a public health advisory and required product manufactures to include a "Boxed" warning for all antipsychotic medications which warn of the potential for increased mortality when antipsychotic medications are used in elderly individuals with dementia related behavioral disorders. Resident # 7 is 82 years old. The pharmacy requested the physician to attempt a gradual dose reduction or provide documentation of the benefits of continuing the Seroquel, that would outweigh the risks, including death. However, the physician responded on 04/04/12 with only a check to continue the current Seroquel therapy without giving any rationale for that decision. On 10/26/12, the pharmacist again requested the physician to review Resident #7's use of the drug Seroquel in regards to the diagnosis of Dementia. The physician had not responded to that request as of 11/01/12. | F 329 | | |



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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 11/01/2012 |
| NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 108 DIECKS DRIVE ELIZABETHTOWN, KY 42701 | |
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| F 329 | <p>Continued From page 9</p> <p>Interview with the contract pharmacist, on 11/01/12 at 10:30 AM, revealed he had requested a reduction in the antipsychotic medication in April 2012 and upon his last visit on 10/26/12. He stated the facility would forward his recommendations to the physicians for consideration and the physicians would usually act upon those recommendations. He said he would review those recommendation upon his next visit to the facility to see what the physician had ordered. He indicated he would request a gradual dose reduction every six months especially in dementia residents.</p> <p>Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), on 11/01/12 at 9:55 AM, revealed the ADON was responsible for monitoring residents' behaviors and psychotropic drug use. She revealed Resident #7 did not receive Psych services provided because the resident's physician declined the service. The physician wanted to order Psych medications and monitor the resident's behaviors himself. The resident had exhibited anxiety and combative behaviors in the past. However, there were no documented behaviors for Resident #7 in the current electronic record. The DON stated the nursing facility monitored behaviors and documented in the record when a behavior occurred. She indicated Psych medications were to be monitored for side effects by all staff. She revealed the pharmacy recommendations were forwarded to the physician by the staff nurses and she did not see the physician's response. She indicated that pharmacist followed-up on the physician's response and she did not monitor to ensure those recommendations were addressed.</p> | F 329 | | |



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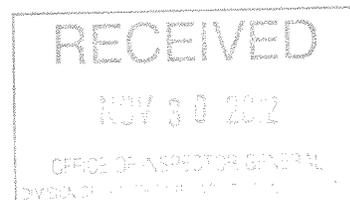
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185183 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/01/2012 |
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| NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 108 DIECKS DRIVE ELIZABETHTOWN, KY 42701 |
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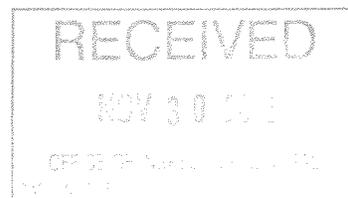
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| F 329 | Continued From page 10 Interview with Resident #7's physician, on 11/01/12 at 9:30 PM, revealed the resident exhibited agitation in the past. The physician did not explain specific behaviors when asked. The physician acknowledged the pharmacist's request for a gradual dose reduction in April 2012 and another request today. The physician would not say what specific condition the antipsychotic medication Seroquel was used to treat. When asked if he was aware of any recent behaviors the resident exhibited, he replied, "No", however, he said the resident had a history of getting agitated and the Seroquel seem to work best. The physician stated he would attempt a gradual dose reduction now. Observation of Resident #7, on 10/30/12 at 12:35 PM, revealed the resident dressed, in a wheelchair, eating lunch. The resident was observed to smile at staff and no anxious behaviors were observed. Continued observation, on 10/31/12 at 8:30 AM, 9:30 AM, 11:15 AM, 12:30 PM, and 2:00 PM, revealed the resident either lying in bed or sitting up in a wheelchair. The resident did not exhibit any behaviors. Review of the most current quarterly assessment, dated 07/31/12, and the annual comprehensive assessment, dated 02/07/12, revealed no behaviors or mood were observed during the assessment period. The facility assessed the resident to have a severe cognition impairment and the resident could only verbalize basic needs. Review of the Care Area Assessment (CAA) for cognition loss revealed the resident had a diagnosis of Dementia with behavior disturbances. The facility stated behaviors are | F 329 | | |
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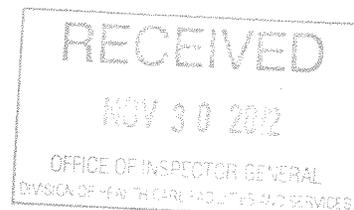
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166183 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/01/2012 |
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| F 329 | Continued From page 11 managed with antipsychotic medication. The resident's affect was pleasant and cooperative. Under the CAA psychotropic drug use, the facility wrote no side effects noted. However, the facility failed to assess the resident for the continued need for the antipsychotic medication and if a gradual dose reduction was to be attempted. Review of the comprehensive care plan dated, 02/14/12, revealed the resident was at risk for mood and behavior alteration with potential for adverse reactions from the antipsychotic medication. Approaches were to evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs. Review for the continued need for drug at least quarterly. However, there was no evidence the facility acted upon these approaches. | F 329 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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 | F 441 | "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." 1) • All bed pans were labeled with a permanent marker and placed in plastic bag in the resident's bathroom on 11/1/12. • The employees clothing, soft drinks, duffel bags, and cell phones were cleaned upon discovery. • The Director of Nursing placed an Isolation signage note on resident #3 door at 10:00am on 10/30/12. | 11/20/12 |



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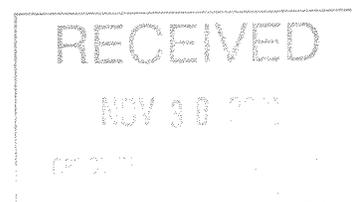
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185183 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/01/2012 |
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| F 441 | <p>Continued From page 12</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide an environment to prevent the development and transmission of disease and infection as evidenced by bedpans observed lying in the floor unlabeled in one (1) resident's room (Room 208), and two (2) of three (3) shower rooms (West and South) observed with employee items, such as employee coats hanging over the shower rod, and duffel bags stored on the dirty trash hampers; a personal cell phone was observed plugged into the outlet beside the shower.</p> <p>In addition, the facility failed to ensure signage for one (1) of fourteen (14) sampled residents was evident on the door (Room 232) to alert visitors of</p> | F 441 | <p>2) The Infection Control Nurse reeducated the nursing staff on 11/2/12, 11/5/12, and 11/7/12 on the bed pan storage policy. The Environmental Supervisor and Infection Control Nurse will monitor resident's room for bed pan storage with resident identification for all 3 shifts x 4 weeks, then every day x 2 weeks, then as determined by the Quality Assurance Committee. Restorative CNA's will check weekly for proper storage and labeling of bedpans. Findings will be reported to the Executive Director with corrective action as indicated weekly.</p> <p>3) The Infection Control Nurse reeducated the nursing staff on 11/2/12, 11/5/12, and 11/7/12 that no employees clothing, soft drinks, duffel bags, and cell phones are to be stored in the shower room. The Environmental Supervisor and Infection Control Nurse will monitor for soiled equipment in the shower areas across all 3 shifts x 4 weeks, then every day x 2 weeks, then as determined by the Quality Assurance Committee. Findings will be reported to the Executive Director with corrective action as indicated weekly.</p> <p>4) Storage of bedpan and personal items will be added to new employee orientation- infection control and yearly with infection control in-service. Began on 11/19/12.</p> | |



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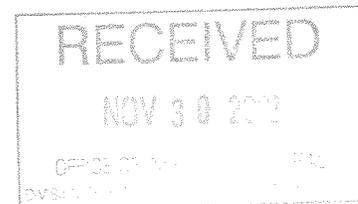
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186183 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 11/01/2012 |
|--|---|--|--|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701 | | |
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| F 441 | <p>Continued From page 13 what infection precautions to use.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Bedpan/Urinal, Offering/Removing, revised October 2010, revealed 13) Store the bedpan or urinal per facility policy. Do not leave it in the bathroom or on the floor, and 14) Place the labeled bedpan or urinal in a plastic bag and leave it in the resident's restroom for next use.</p> <p>1. Observation on tour, on 10/30/12 at 12:30 PM, revealed the bathroom of Room 208 had four (4) bedpans; two (2) were lying on the floor with no label or cover, and one (1) was sitting on the hand rail beside the commode with no label or cover. The fourth bedpan was hanging on the hand rail covered by a plastic bag; however, the bedpan had no label to identify the resident. Observation of Room 208, on 11/01/12 at 12:10 PM, revealed three (3) bedpans in the bathroom, all covered with plastic, however none were labeled for identification.</p> <p>Interview with CNA #6, on 11/01/12 at 12:30 PM, revealed all bedpans should be labeled with a permanent marker and labeled, and put in plastic bags kept in the bathroom; the CNA did not know why there were four (4) bedpans in that room for two (2) residents.</p> <p>Interview with LPN #1, on 11/01/12 at 12:14 PM, revealed bedpans should not be lying on the floor, and should be labeled and stored in a plastic bag per policy.</p> <p>Interview with the DON, on 11/01/12 at 1:50 PM,</p> | F 441 | <p>5) Nursing staff reeducated by Infection Control Nurse on 11/2/12, 11/5/12, and 11/7/12 to notify infection control nurse immediately of Isolation orders. Infection Control Nurse will review all new infections that require Isolation to ensure that proper Isolation procedures and signage are initiated immediately at time of order. Infection Control Nurse will also initiate plan of care for Infection and Isolation procedures. The Infection Control Nurse will continue to monitor for twelve months.</p> <p>6) The Infection Control Nurse reeducated the nursing staff on Helmwood's resident Isolation policy on 11/2/12, 11/5/12, and 11/7/12.</p> <p>7) Trends identified through auditing analysis will be reviewed for twelve months at the monthly Quality Assurance Committee for any additional follow up and/or in-services needs.</p> | | |



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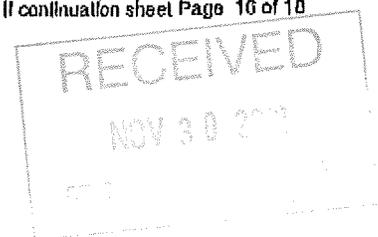
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186183 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/01/2012 |
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| NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701 | |
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| F 441 | <p>Continued From page 14</p> <p>revealed the bedpans should not be stored in the floor and the potential was a risk for infection issues.</p> <p>Interview with the Administrator, on 11/01/12 at 4:45 PM, revealed he completed a full walk through one day a week, and if there are issues, there was on the spot training at that time. Further interview with the administrator revealed they now have permanent markers labeling all the items in the bathroom; however, stated they had gotten away from teaching this with the new staff.</p> <p>Interview with the DON, on 11/01/12 at 1:50 PM, revealed there was no policy to address leaving employee personnel items in the residents' shower room.</p> <p>2. Observation on tour, on 10/30/12 at 12:25 PM, revealed the West Shower room had two (2) employee coats hanging over the shower rod in the shower; there was also one large duffel bag with the name "Nursing Assistant" on the front. Further observation of the West Shower room, on 10/31/12 at 11:15 AM, revealed a duffel bag on top of the trash hamper stored in the shower room, with a personal cell phone plugged into the outlet; there were dirty gloves lying in the floor of the shower room.</p> <p>Tour of the South shower room, on 10/30/12 at 12:45 PM, revealed 3 jackets hanging up on hooks with 3 large duffel bags with the name "Nursing Assistant" on the front. In addition, there was an opened drink can sitting on the sink.</p> <p>Interview with CNA #6, on 11/01/12 at 12:30 PM, revealed they were allowed to keep the duffel</p> | F 441 | | |



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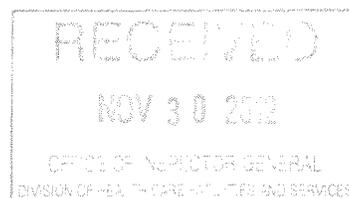
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185103 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/01/2012 |
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| NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 108 DIECKS DRIVE ELIZABETHTOWN, KY 42701 | |
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| F 441 | <p>Continued From page 15</p> <p>bags, that were given to the staff last year, in the shower room, because they were used as shower bags. The CNA stated the shower bags contained shampoo and shower items used for residents; however, revealed they were not all used for this, and the duffel bags were used by some staff as personal bags. Interview with CNA #6 also revealed she had permission to keep her phone in the shower room because she had a sick baby at home and didn't give out the number. The CNA admitted these issues could pose an infection control problem.</p> <p>Interview with the Director of Nursing (DON), on 11/01/12 at 1:50 PM, revealed employees were not allowed to keep their personal items in the shower room, and permission had not been given to plug cell phones or store in the shower room. The DON stated there had been reports some time ago that staff were storing their personal items in the shower room, and on the spot training had been completed at that time. The DON stated there were lockers available downstairs for personnel item storage and should not be stored in the shower room. The DON stated the Environmental Department, Infection Control Nurse, and herself were responsible for monitoring the shower rooms, with on the spot checks completed. The DON also stated they had found this occurred every year when the weather started turning colder.</p> <p>Interview with the Administrator, on 11/01/12 at 4:45 PM, revealed he completed a walk-through of the facility one day a week and when he found personal items in the shower room, he completed an on the spot training. The Administrator stated this posed a risk of infections to residents with the</p> | F 441 | | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106163 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/01/2012 |
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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 441 | Continued From page 16 personal items being left in the shower room. The Administrator also revealed, although this was not a new problem, it had not been taken to Quality Assurance meeting. 3. Review of Resident #3's clinical record revealed the facility admitted the resident on 06/24/09 and had diagnoses of Ulcerative Colitis and Clostridium-Difficile (C-Diff). Observation during Tour, on 10/30/12 at 9:27 AM, revealed no isolation signage noted on the door to Resident #3's room. Interview with Resident #3, on 10/30/12 at 9:30 AM, revealed he/she was in isolation and did not know why. Interview with Certified Nursing Assistant (CNA) # 4, on 10/31/12 at 2:46 PM, revealed she worked the day of the tour and was aware Resident #3 was in isolation for C-Diff, but was not aware there was no signage on the door. Interview with Licensed Practical Nurse (LPN) #2, on 11/01/12 at 10:02 AM, revealed she was not aware there was no isolation signage on Resident #3's door. LPN #2 stated there should have been signage on the door and that it was a normal practice to have isolation signage on the door. When asked how would visitors and new staff know if Resident #3 was in isolation, the Nurse responded they would see the red biohazard bins in the door way and know the resident was on isolation. Interview with the Director of Nursing (DON), on 11/02/12 at 2:47 PM, revealed the isolation signage was supposed to be on the door. Nurses were aware of the isolation because the information could be found on the 24 hour report. | F 441 | | |



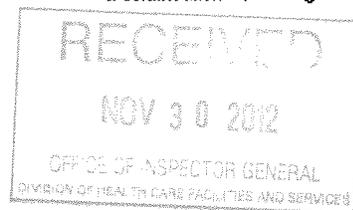
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185183 | (X2) MULTIPLE CONSTRUCTION (AD SERVICES) A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 10/30/2012 |
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| 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 Unprotected.</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments; five (5) in the Ground Floor and two (2) in the Basement.</p> <p>FIRE ALARM: Complete fire alarm system with heat and 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 10/30/12. 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 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 latch in room 243 was adjusted to work properly by maintenance director on 10/30/12.</p> <p>2) The latches in each room were checked by maintenance director to assure properly working condition on 10/30/12.</p> <p>3) The latch/door information will be included in the routine fire and safety in-service by the maintenance director.</p> <p>4) The monitoring program to assure resident's door's latch properly will be done every week for 3 months by the maintenance director. The monitoring program will continue monthly.</p> <p>5) Audit information will be evaluated with any identified trends reviewed at the monthly Quality Assurance Committee/Safety Committee for any additional follow up and/or in-services needs.</p> | 10/31/12 |
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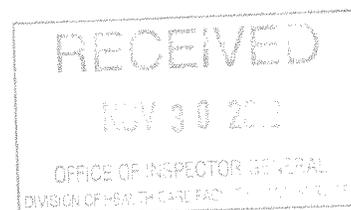
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jason Jones</i> | TITLE <i>Correction Director</i> | (X6) DATE <i>11/30/12</i> |
|---|-------------------------------------|------------------------------|

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: 11/02/2012
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 10/30/2012 |
|---|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECK\$ 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 | Continued From page 1 | K 000 | | |
| K 018 SS=D | <p>Deficiencies were cited with the highest deficiency identified at "D" 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 there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments on the Ground Floor, approximately fifteen (15) residents, staff, and</p> | K 018 | | |



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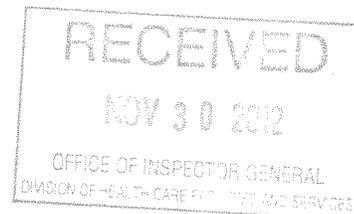
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| NAME OF PROVIDER OR SUPPLIER HELMWOOD HEALTHCARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 108 DIECKS DRIVE ELIZABETHTOWN, KY 42701 |
|--|--|

| (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 |
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| K 018 | <p>Continued From page 2</p> <p>visitors. The facility has sixty (60) certified beds and the census was fifty-three (53) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/30/12 at 9:38 AM, with the Environmental Services Director revealed the door to resident room 243 did not latch when tested.</p> <p>Interview, on 10/30/12 at 9:38 AM, with the Environmental Services Director revealed the door would not latch and remain closed to resist the passage of smoke in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or</p> | K 018 | | |
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| K 018 | Continued From page 3 combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. | K 018 | | | |

