

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2011
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 10/04-06/11 and a Life Safety Code survey was conducted on 10/04/11 with deficiencies cited at the highest scope and severity at an "F". The facility had the opportunity to correct the deficiencies before imposition of remedies would be recommended.	F 000		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to follow the care plan for three (3) of sixteen (16) sampled residents. Residents #8 and #10 did not have the lap buddy restraint removed during lunch on 10/04/11. In addition, Residents #10 and #16 did not have nose cups as indicated on the comprehensive care plan during lunch on 10/04/11.  The findings include:  Review of the facility's policy "Care Plans, Goals and Objectives", not dated, revealed the care plan shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Goals and objectives are entered on the resident's care plan to ensure all	F 282	"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 resident #8, and 10 all care plans have been reviewed and updated as of 10/9/2011 to reflect restraint device and when it is to be removed.  2) On resident #8, and 10 the cna care guide has been updated as of 10/9/2011 to reflect restraint devices and when to be removed.  3) All other residents in the facility with restraints and other devices, their care plan and cna care guide had been reviewed and updated to reflect appropriate devices and when to remove.  4) All staff will be in serviced on 11/14/2011 and make up on 11/18/2011 on restraints (devices) and appropriate use and removal of. Also in serviced on checking care guides daily for any changes. In-services will be completed 11/19/2011  5) New employee orientation will include restraints (devices) use of and removal of to ensure all new hires are properly trained. Also will be in serviced on checking care guides daily for any changes.	11/19/2011

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

TITLE

(X6) DATE

*[Signature]*

*X Administrator*

*X 11/3/11*

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

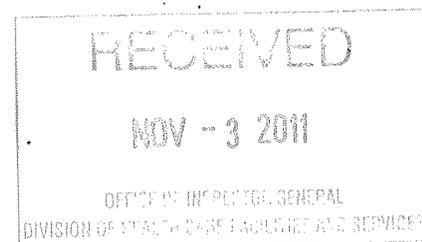
PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2011
--	--	--	--

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 282	<p>Continued From page 1 disciplines have access to the information.</p> <p>Observation, on 10/04/11 at 12:40 PM, revealed Residents #8 and #10 in the south dining room eating lunch. Both residents had the lap buddy restraint in use. The restraints remained on the residents during the entire meal service.</p> <p>Observation, on 10/04/11 at 1:10 PM, revealed Residents #10 and #16 had meal cards indicating the use of a nose cup. Observation revealed neither resident had a nose cup on the tray and staff did not recognize the nose cups were missing.</p> <p>Review of the comprehensive care plan for Resident #8 revealed the resident had an order for a lap buddy when up in the wheelchair. The care plan indicated to remove the lap buddy during meals.</p> <p>Review of the comprehensive care plan for Resident #10 revealed an approach was added on 05/31/11 to include, a lap buddy for safety and positioning while in the wheelchair, remove lap buddy during meals. In addition, an approach was added on 07/06/11 for the resident to have a nose cup at meals.</p> <p>Review of the comprehensive care plan for Resident #16 revealed an approach added on 08/12/11 that included, the use of a nose cup, with no straws during meals.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 10/04/11 at 1:15 PM, revealed she did not look at the tray cards when the resident's trays were delivered, only the menu the residents or</p>	F 282	<p>6) Care plans will be reviewed by the interdisciplinary team after each MDS completed and after any significant change</p> <p>7) All devices will be reviewed monthly in safety/restraint/behavior meetings.</p> <p>8) The Administrator will audit the removal of devices during breakfast meal times. The Dietary Manager will audit the removal of devices during lunch meal times. The SDC nurse will audit the removal of devices during supper meal times. The weekend charge nurse will audit the removal of devices during all meal times over the weekend.</p> <p>9) On resident # 10 and 16 care plans have been reviewed and updated with appropriate adaptive equipment(nosey cups) as of 10/09/2011</p> <p>10) On resident # 10 and 16 cna care guides have been reviewed and updated with the appropriate adaptive equipment(nosey cups) as of 10/09/2011</p> <p>11) Dietary Manager in serviced dietary staff on resident s # 10 and 16 regarding ensuring residents has the proper adaptive equipment as ordered. This was completed on 10/09/2011</p> <p>12) Effective 11/2/11 adaptive equipment has been added to menus. This is located at the top with diet in blue. It has been moved to top of tray card with diet in blue. (see attached)</p>	
-------	--	-------	--	--



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

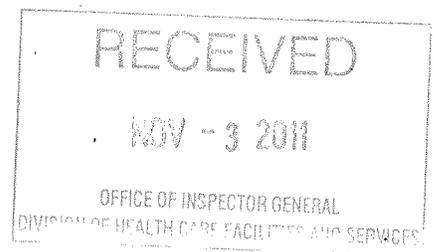
PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2011
--	--	--	--

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
--------------------	--	---------------	---	----------------------

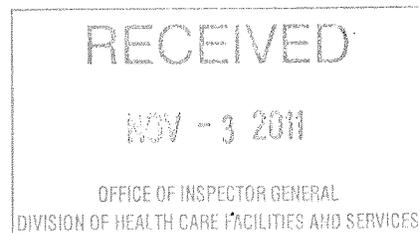
F 282	<p>Continued From page 2</p> <p>families filled out, with the choice of food for that meal.</p> <p>Interview with CNA #3, on 10/04/11 at 1:20 PM, revealed the kitchen staff was responsible for putting the nose cups on the tray.</p> <p>Interview with the Restorative CNA #1, on 10/06/11 at 9:15 AM, revealed any new changes to the care plan were put on the comprehensive care plan and the CNA care plan. The CNA care plans were kept on the inside of the closet door of each resident. CNA #1 stated she was aware residents who had lap buddies and/or restraints were removed or released during meals. She stated they just forgot to take them off on 10/04/11 at lunch. CNA #1 stated the reason the restraints are removed during meals was for dignity, and allowed the resident to get closer to the table.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/06/11 at 10:55 AM, revealed the nurses did not go in the dining rooms to assist with meals unless the CNA's needed help. She stated she was not aware if audits were done in the dining room to ensure residents were getting the appropriate meal, assistive devices, or if restraints were removed.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 10/06/11 at 11:00 AM, revealed there was usually at least three (3) CNA's in the south dining during meals, as that was the dining room where the residents who needed the most assistance ate. She stated the facility had completed periodic audits of the dining rooms. The last audit was completed on 10/01/11 and</p>	F 282	<p>13) All staff will be in serviced by Dietary Manager on tray cards on 11/14/2011 and make up on 11/18/2011 to the importance of reading tray cards. This will also be included in New employee orientation to ensure proper training of all new hires. In-services to be completed by 11/19/2011</p> <p>14) Dietary staff while on tray line will do 1<sup>st</sup> check of proper adaptive equipment before trays leaves the kitchen. Nursing will do the 2<sup>nd</sup> check before passing trays to ensure proper adaptive equipment is available.</p> <p>15) The Administrator will audit the tray cards to insure the proper equipment is available during breakfast meal times. The Dietary Manager will audit the tray cards to insure the proper equipment is available during supper meal times. The SDC nurse will audit the tray cards to insure the proper equipment is available during supper meal times. The weekend charge nurse will audit tray cards to insure the proper equipment is available during all meal times over the weekend. Auditing will continue twelve weeks of 100% compliance is met. Periodic audits will continue to ensure continued compliance every quarter.</p> <p>16) If there are any absences during the audits, Administrator will be covered by Assistant Director of Nursing, Dietary Manger will be covered by Director of Nursing, SDC nurse will be covered by MDS nurse, and the weekend charge nurse will be covered by the nurse on call.</p> <p>17) Trends identified will be reviewed at the monthly by the Quality Assurance Committee for any additional follow up and/or in-services needs.</p>	
-------	---	-------	---	--



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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2011
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 282	Continued From page 3 09/23/11. Review of the audit form with the ADON revealed there was not an entry for removing restraints during meals. The ADON stated it was necessary to remove the lap buddies during meal service as that was the residents right and it allowed the resident to get closer to the table.	F 282		
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE  The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.  This REQUIREMENT is not met as evidenced by: Based on interview and review of the nurse aide training records it was determined the facility failed to ensure all nurse aides received no less than twelve (12) hours per year of continuing education. One nurse aide was allowed to work with only 5.75 hours of continuing education from June 2010.  The findings include:	F 497	"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) Corrective Action: Following the survey visit all in-service records were re-audited to calculate nurse aid education hours by the SDC nurse.  2) Staff Development Tracking Form for in-service attendance was initiated by the SDC nurse on 10/07/11.  3) A documentation system for nursing assistants, tracking 12 hours/12 months based on hire date was initiated on 10/07/11 by the SDC nurse.  4) In-service/education sign in sheets systems were refined to include content, outline and hours earned. This was implemented 10/07/11.	10/31/11



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

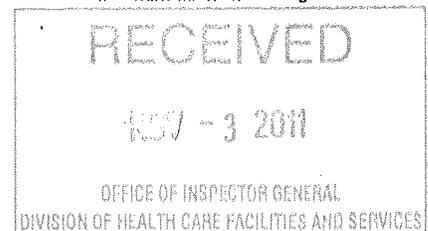
PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2011
--	--	--	--

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 497	Continued From page 4 Review of the nurse aide training records on 10/06/11 revealed one nurse aide with a hire date of 08/16/09 only received 5 hours and 75 minutes from June 16, 2010 to October 6, 2011.  On 10/06/11 at 2:45 PM, an interview with the Infection Control/Staff Development Coordinator, who conducted the nurse aide training's and was responsible for ensuring all nurse aides obtain the minimum twelve (12) hours per year, revealed he was unaware you were to calculate the training hours from hire date to annual date instead of January to December. He stated he was new in this position and he was not trained to calculate the hours according to the regulations. He revealed the nurse aide who did not have the required twelve (12) hours of continuing education had been on FMLA (family medical leave act) from June 23, 2011 to September 1, 2011 and had not attended any continuing education classes since her return. However, the nurse aide should have completed the required 12 hours by June 16, 2011, prior to the start of FMLA.	F 497	5) The SDC nurse will review the nursing assistant hours on a monthly basis. This will be completed by 10/31/11.  6) Effective 10/31/11 the Director of Nursing will audit in-service training records quarterly to insure nursing assistants are receiving required training/education.	
-------	---	-------	--	--



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

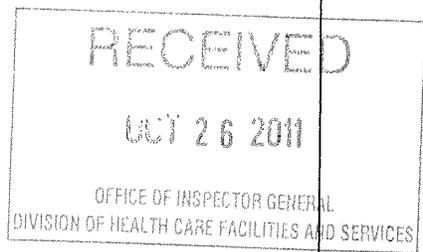
PRINTED: 10/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

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  10/04/2011
--	--	--	--

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
--------------------	--	---------------	---	----------------------

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: Two story, Type II Unprotected</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</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 10/04/11. Helmwood Healthcare Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty (60) beds with a census of sixty (60) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
-------	---	-------	--	--



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Jason Jones</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 10/24/11</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

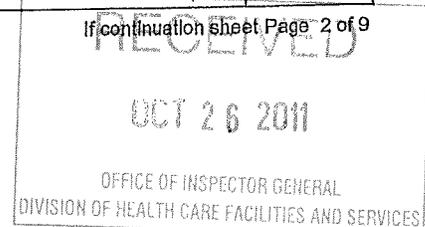
PRINTED: 10/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

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  10/04/2011
--	--	--	--

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

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

K 000	Continued From page 1	K 000		
K 038 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of sixty (60) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/04/11 at 2:15 PM, with the Maintenance Staff revealed the South Hall Exit did not have a durable surface leading to a public way. Further observation revealed work had been started to install a durable surface, but no contractors were on site the day of the survey.</p> <p>Interview, on 10/04/11 at 2:15 PM, with the Maintenance Staff revealed work had been</p>	K 038	<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>Schaefer Contracting is on site completing the concrete ramp (durable surface leading to public way) to be compliance with section 7.1 19.2.1.</p> <p>Schedule is as follows with weather permitting:</p> <p>1) Utility relocation: The relocation work should take 1 complete day.</p> <p>2) Demolition: Once the utilities are relocated the demolition should take 2 days.</p> <p>3) Concrete: After demolition the concrete work is scheduled. Allow 2 weeks for concrete.</p> <p>4) Site work: Backfill and finish grade disturbed area, seed and straw. Allow 2 days.</p>	11/18/11



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

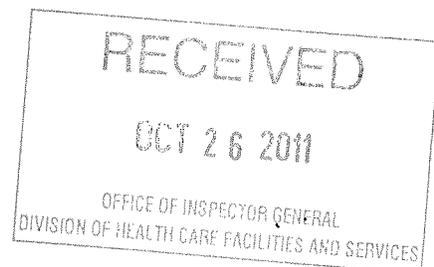
PRINTED: 10/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

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  10/04/2011
--	--	--	--

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

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

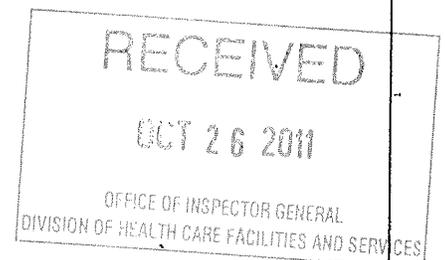
K 038	Continued From page 2 started to install a durable surface, but the staff did not have a confirmed completion date, and they did not know when the contractors would return to work.	K 038	5) Steel Hand Rails: Steel hand rails will be field measured for fabrication. Within 8-10 days the hand rails will be installed.	
K 144 SS=F	Exits must have a durable surface to the public way to support wheelchairs, beds, equipment, etc., in case of an emergency situation. NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	6) Paint: In the last phase hand rails are painted. Allow 2 days 7) Plan to complete within four weeks. 8) Trends identified will be reviewed at the monthly by the Quality Assurance Committee/Safety Committee for any additional follow up and/or in-services needs.	
	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 seven (7) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of sixty (60) on the day of the survey.  The findings include:  Observation, on 10/04/11 at 2:25 PM, with the Maintenance Staff revealed the annunciation panel for the emergency generator located at the	K144	"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) A new annunciation panel for the emergency generator has been ordered from the Varitech Company system and will be available on 11/8/11.	11/8/11



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

PRINTED: 10/10/2011  
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  10/04/2011
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	<p>Continued From page 3</p> <p>nurses' station was not functional. The annunciation panel was equipped with a Lamp Test button, but when pushed, no lamps would come on to indicate the panel was functioning.</p> <p>Interview, on 10/04/11 at 2:25 PM, with the Maintenance Staff revealed they were not aware the annunciation panel did not function.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 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 Where a regular work station will be unattended</p>	K 144	<p>2) The new annunciation panel will indicate alarm conditions of emergency or auxiliary power source. The new annunciation panel will insure: (a) individual visual signals shall indicate the following: (1) when the emergency or auxiliary power source is operating to supply power to load, (2) when the battery charger is malfunctioning, (b) Individual signals plus a common audible signal to warn of engine-generator alarm condition of low lubricating oil pressure, low water temperature, excessive water temperature, low fuel, overcrank, and overspeed.</p> <p>3) The maintenance director will ensure that the annunciation panel responds to trouble signals in accordance with NFPA 70 Section 700-12.</p> <p>4) The monitoring program to assure the annunciation panel and generator is in proper working condition will be done weekly by the maintenance director.</p> <p>5) Trends identified will be reviewed at the monthly by the Quality Assurance Committee/Safety Committee for any additional follow up and/or in-services needs.</p>	



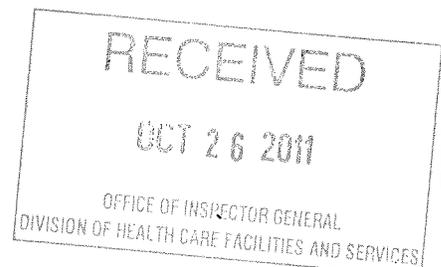
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2011  
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  10/04/2011
--	--	--	--

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

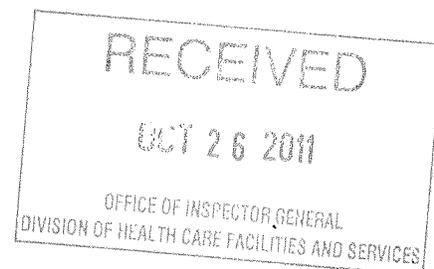
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 4 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]	K 144		
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of sixty (60) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/04/11 between 9:30 AM and 4:30 PM, with the Maintenance Staff revealed:</p> <ol style="list-style-type: none"> <li>1) Storage rack of pans was stored in front of electrical panels, located in the Kitchen.</li> <li>2) An air pump for a resident mattress was plugged into a power strip located in Room #249.</li> <li>3) A refrigerator plugged into an extension cord that was plugged into a power strip located in Room #248.</li> </ol>	K 147	<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> <ol style="list-style-type: none"> <li>1) The rack of pans were removed from the front of the electrical panels in the kitchen by the maintenance director on 10/05/11.</li> <li>2) All refrigerators and resident medical equipment are plugged into the correct power source. This was corrected by the maintenance director on 10/05/11.</li> <li>3) All extension cords were removed from the center on 10/05/11 by the maintenance director</li> </ol>	10/31/11



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

PRINTED: 10/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

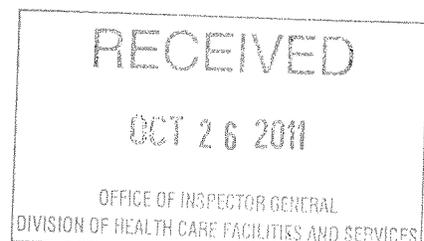
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  10/04/2011
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 5</p> <p>4) An air pump for a resident mattress, and a lift chair were plugged into a power strip located in Room #242.</p> <p>5) A refrigerator was plugged into a power strip located in Room #232.</p> <p>This is a repeat deficiency from 2009.</p> <p>Interview, on 10/04/11 between 9:30 AM and 4:30 PM, with the Maintenance Staff revealed they were unaware of the extension cords and power strips being misused. They were also unaware the Kitchen Staff had moved the pan rack in front of the electrical panels. The Maintenance Staff also revealed they had forgotten about the previous deficiency regarding power strips.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p>	K 147	<p>4) The administrator discussed with the families on 10/15/11 at the Family Meeting that extension cords are prohibited from the center and power strips cannot be used for refrigerators or any medical equipment.</p> <p>5) We had three different electric contactors visit the center 10/20/11. We are waiting on bids from the three (adding 240 additional power outlets).</p> <p>6) The nursing staff will be reeducated by the maintenance director regarding resident care of electric appliances and which power sources to use on 10/31/11.</p> <p>7) The Maintenance Director will look for unauthorized extension cords and insure the proper equipment is plugged into power strips. This will be done on a monthly basis.</p> <p>8) Trends identified will be reviewed at the monthly by the Quality Assurance Committee/Safety Committee for any additional follow up and/or in-services needs.</p>	



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

PRINTED: 10/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

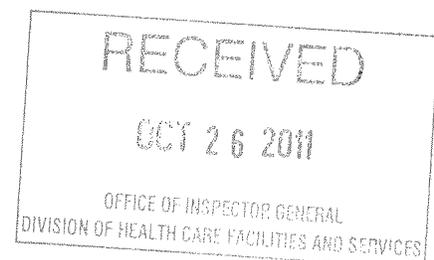
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  10/04/2011
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 6 About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147		
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source in	K 211	<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 alcohol based hand rub dispensers were moved (4) ft from each other. The alcohol based hand rub dispensers were also moved to insure none were above any light switch or ignition source. They were relocated by the maintenance director on 10/05/11.</p> <p>2) The maintenance staff has been reeducated by the maintenance director that alcohol based hand rub dispensers cannot be located or installed over a light switch or an ignition source. The dispensers must have a minimum spacing of 4 ft from each other in a long term care facility.</p> <p>3) Trends identified will be reviewed at the monthly by the Quality Assurance Committee/Safety Committee for any additional follow up and/or in-services needs.</p>	10/05/11



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

PRINTED: 10/10/2011  
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  10/04/2011
NAME OF PROVIDER OR SUPPLIER  HELMWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 DIECKS DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	<p>Continued From page 7</p> <p>accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of sixty (60) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/04/11 between 9:30 AM and 4:00 PM, with the Maintenance Staff revealed Alcohol Based Hand Rub dispensers were installed over or adjacent to the light switches in Room #226, 241, and 243.</p> <p>Interview, on 10/04/11 between 9:30 AM and 4:00 PM, with the Maintenance Staff revealed they were not aware that the dispensers were not allowed to be mounted above an ignition source.</p> <p>Reference:</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> </ul>	K 211		



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

PRINTED: 10/10/2011  
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  10/04/2011
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 8 o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		

