

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

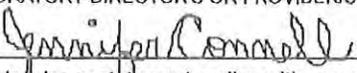
PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ NOV 2012	(X3) DATE SURVEY COMPLETED 10/19/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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 recertification survey was conducted on 10/16/12 through 10/19/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of an "E."	F 000	1. Corrective Action: The towels were removed from the bathroom floor and the floor was mopped in room 301 on 10/19/2012. All residents that use towels have the potential to be affected by this practice. The housekeeper who responded it was not her responsibility to pick up dirty towels from the floor was counseled that it is her job responsibility to pick up anything including soiled towels from the floor. The housekeeper voiced understanding of this requirement to her supervisor. We are unable to identify nurse aide #1 but he or she will be educated collectively in a joint in-service with nurse aides and environmental services on 11/19/12. The in-service will include how to handle dirty linens and the expectations regarding the employee's responsibility to be observant and take action when towels or other objects are on the floor. In order to monitor performance and ensure solutions are sustained: The Housekeeping/Laundry Supervisor will include on rounds the observation of the residents' bathroom floors for the presence of dirty towels. The Housekeeping/Laundry Supervisor will communicate to the Director of Nursing (DON) if dirty towels are being overlooked by nursing and/or housekeeping staff.	11/30/12
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary interior. Observation of Room #301 on 10/16/12 through 10/19/12, revealed soiled towels on the bathroom floor and on the towel rack. Additionally, observation of exhaust fan vents in seven resident bathrooms revealed thick particles of dust. Findings include: 1. Observation of the resident's bathroom in Room #301, on 10/16/12 at 10:45 AM, on 10/17/12 at 9:30 AM, on 10/18/12 at 2:45 PM, and on 10/19/12 at 9:20 AM, revealed a towel rack with one towel noted to have an orange substance on it. There were also multiple soiled towels behind the trash can in the bathroom.	F 253	2. Corrective Action: The bathroom exhaust fans for rooms 301, 305, 307, 104, 107, 108, 111 were cleaned 10/22/2012. All residents have the potential to be affected by this practice. Systemic Changes: The Maintenance schedule for cleaning the exhaust fan vents in the resident's bathrooms will be structured within a specified time frame instead of a flexible "monthly" schedule. Monitor Performance: A deficiency correction task checklist has been developed for Maintenance included on the list is exhaust fan cleaning. The Administrator, while making compliance rounds, will compare tasks listed on the checklist as completed with visual inspection.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administration	(X6) DATE 11/09/12
---	-------------------------	-----------------------

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2012	
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 253	<p>Continued From page 1</p> <p>Interview with Resident #16, on 10/16/12 at 10:45 AM, and on 10/18/12 at 2:45 PM, revealed he/she had asked the staff to replace the soiled towels; however, the soiled towels were not replaced. The resident stated "I guess they will pick the towels up one day."</p> <p>An interview with Housekeeper, on 10/19/12 at 1:05 PM, revealed she had just cleaned the bathroom floor in Room #301. She revealed it was not her responsibility to pick up dirty towels from the floor.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 10/19/12 at 1:25 PM, revealed towels were replaced every shift and as needed. She was responsible for the care of Resident #16 in Room #301 on 10/18/12 and on 10/19/12; however, she did not notice the soiled towels in the bathroom.</p> <p>An interview with the Housekeeping Supervisor, on 10/19/12 at 3:10 PM, revealed she expected the housekeeping staff to pick up dirty items from the floor while cleaning and to clean behind trash cans.</p> <p>An interview with the Director of Nursing (DON), on 10/19/12 at 2:40 PM, revealed the CNAs should check for soiled items when in a resident's room; however, housekeeping was also responsible for picking up soiled laundry from the floor.</p> <p>2. A review of the facility's policy/procedure for Monthly Vent/Air Conditioning Cleaning, undated, revealed there would be monthly cleaning of the exhaust fan vents in the bathrooms by Housekeeping and/or Maintenance.</p>	F 253		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 253	Continued From page 2 The following observations made upon initial tour of the facility, on 10/16/12 at approximately 10:30 AM, revealed: a). The resident's bathroom in Room #301 revealed a thick build-up of grayish white particles on the exhaust fan vent. b). The resident's bathroom in Room #305 revealed brown, dusty particles on the exhaust fan vent. c). The resident's bathroom in Room #307 revealed brown particles on the exhaust fan vent. d). The exhaust fan vents in residents' bathrooms in Rooms #104, #107, #108, and #111 had a build-up of dust and debris. A review of the Bathroom Exhaust Fan Cleaning Log, dated 2012, revealed there were initials for September 2012, which meant completed; however, there were no initials for October 2012. An interview with the Maintenance Director, on 10/19/12 at 1:40 PM, revealed it was his responsibility to clean the exhaust fan vents in the residents' bathrooms. He revealed the vents were cleaned monthly; however, cleaning had not started for October, 2012.	F 253		
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	F 279	The care plan for resident #11 was updated on 10/15/2012. No further action was warranted. All other residents assessed as high risk for falls have the potential to be affected by the same practice. Systemic Changes: All residents assessed as high risk for falls will be care planned with appropriate interventions to address individual risk factors. Monitor Performance: The DON or RN designee will conduct admission care plan audits comparing fall risk and individual care plan focus, intervention, and goals.	12/7/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
--	--

(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 279	<p>Continued From page 3</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</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, review of the facility's Fall Investigation, and review of the facility's policy/procedure, it was determined the facility failed to develop a comprehensive plan of care for one resident (#11), in the selected sample of 14 residents, that included measurable objectives and timetables to meet a resident's medical and nursing needs that were identified in the comprehensive assessment. The facility identified Resident #11 at high risk for falls upon admission; however, did not develop a comprehensive care plan to ensure fall risk factors were addressed with interventions in place.</p> <p>Findings include:</p> <p>A review of the facility's Comprehensive Care Plan policy/procedure, undated, revealed the facility would develop a comprehensive care plan for each resident that included measurable</p>	F 279		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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 279 Continued From page 4
objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. The care plan must describe the services that were furnished to attain or maintain the patient's highest practicable physical, mental, and psychosocial well-being.

A record review revealed the facility admitted Resident #11 on 09/25/12 with diagnoses to include Hemiplegia and Osteoarthritis. A review of the initial Minimum Data Set (MDS), dated 10/05/12, revealed the facility identified the resident as cognitively intact and required extensive assistance for bed mobility, transfers, and ambulation. A review of the Fall Risk Assessment, dated 09/25/12, revealed the facility assessed the resident at high risk for falls related to a history of falls, narcotic use, frequent incontinence of bladder, and the inability to transfer and ambulate without assistance.

A review of the facility's Fall Investigation, dated 10/14/12, revealed the resident sustained a fall after sliding from the wheelchair. A review of the resident's comprehensive care plan, initiated 10/15/12, revealed the resident was at risk for falls related to a poor safety awareness and an actual fall; however, there was no evidence of a care plan prior to 10/15/12.

An interview with the MDS Coordinator, on 10/19/12 at 4:00 PM, revealed prior to the resident's actual fall, she did not feel the resident was "at risk" for falls. She revealed the resident did not try to get up unassisted and always used the call light for assistance. She revealed she did not feel a care plan should have been put in place

F 279

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2012	
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 279	Continued From page 5 prior to the actual fall.	F 279		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure each resident received adequate assessment and supervision to prevent accidents for one resident (#11), in the selected sample of 14 residents. The facility assessed Resident #11 at a high risk for falls upon admission, on 09/25/12. The resident sustained a fall on 10/14/12; however, the facility had not implemented a plan of care related to the resident's fall risk factors.</p> <p>Findings include: A record review revealed the facility admitted Resident #11 on 09/25/12 with diagnoses to include Hemiplegia and Osteoarthritis. A review of the initial Minimum Data Set (MDS), dated</p>	F 323	<p>The care plan for resident #11 was updated on 10/15/2012. No further action was warranted. All other residents assessed as high risk for falls have the potential to be affected by the same practice. Systemic Changes: All residents assessed as high risk for falls will be care planned with appropriate interventions to address individual risk factors. Monitor Performance: The DON or RN designee will conduct admission care plan audits comparing fall risk and individual care plan focus, intervention, and goals.</p>	12/7/2012

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 323	<p>Continued From page 6</p> <p>10/05/12, revealed the facility assessed Resident #11 as cognitively intact and required extensive assistance with bed mobility, transfers, and ambulation.</p> <p>A review of the Fall Risk Assessment, dated 09/25/12, revealed the resident was at high risk for falls related to the following risk factors:</p> <ol style="list-style-type: none"> 1). history of falls 1-2 times within the last six months 2). narcotic use 3). frequent incontinence of bladder 4). unable to independently come to a standing position 5). exhibited loss of balance while standing 6). required hands-on assistance to move from place to place <p>A review of the facility's Fall Investigation, dated 10/14/12, revealed the resident slipped out of his/her wheelchair landing on the floor.</p> <p>A review of the Fall Risk comprehensive care plan, initiated 10/15/12, revealed the resident was at risk due to poor safety awareness and an actual fall; however, there was no evidence of a comprehensive care plan to address the resident's risk for falls or interventions to prevent a fall prior to 10/15/12.</p> <p>An interview with the MDS Coordinator, on 10/19/12 at 4:00 PM, revealed the Fall Risk Assessment was just one tool used to help determine a resident's risk for falling at the facility; however, it was not the deciding factor. She revealed Resident #11 had some confusion; however, he/she had not attempted to stand alone and always used the call light for</p>	F 323			

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 323	Continued From page 7 assistance. For those reasons, she did not feel Resident #11 was at risk for falls. She stated when Resident #11 sustained the fall on 10/14/12, he/she was not attempting to get up unassisted. An interview with the Director of Nursing (DON), on 10/19/12 at 4:35 PM, revealed the nursing staff do not only use the Fall Risk Assessment as a deciding factor whether or not to care plan a resident for a fall risk; however, she expected risk factors for falls to be addressed on the care plan with interventions.	F 323			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure it was free of medication error rates of five percent or greater. Observation of a medication pass, on 10/18/12 at 9:00 AM, revealed 40 opportunities with four medication errors which resulted in a five percent (5%) medication error rate. Findings include: A review of the facility's Medication Pass Administration policy, no date, revealed the five rights of accurate Medication Administration were right drug, right dose, right time, right route and right resident. The staff should also consider	F 332	A disciplinary action of suspension was imposed upon LPN #1. Prior to returning to work, LPN #1 was educated by the DON regarding policy and proper procedure for measuring medications including those less than 5 ml. Other residents requiring liquid medications have the potential to be affected by this practice. Measures: Currently employed Licensed Nurses and Kentucky Medication Aides will be required to attend education regarding proper medication administration and to demonstrate proficiency in medication administration including liquid medications. Demonstrations will be required of new employees during the orientation process upon hire. Monitor Performance: Random performance audits will be conducted by the DON on every Licensed Nurse and Kentucky Medication Aide a minimum of twice a year.	12/21/2012	

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 332	Continued From page 8 right dosage form, right to refuse and right to self-administer. A review of Resident #17's physician's orders, dated 10/2012, revealed Furosemide (diuretic) Solution 10 milligram (mg)/milliliter(ml), four ml (40 mg) per gastric tube twice daily, and Ranitidine 15 mg/ml syrup 3.3 ml (50) mg per gastric tube twice daily. Observation of a medication pass, on 10/18/12 at 9:00 AM, revealed Licensed Practical Nurse (LPN) #1 used a small plastic medication cup to measure the amount of Furosemide and Ranitidine for administration. The first measurement indicated on the measuring cup was five (5) ml. LPN #1 poured both the Furosemide and Ranitidine into two different medication cups and stopped pouring just below the five (5) ml line on the cup. Interview with LPN #1, on 10/18/12 at 10:00 AM, revealed she estimated where 4 ml and 3.3 ml would be in the cup, based on where the 5 ml line was on the cup. Interview with the Director of Nursing (DON), on 10/19/12 at 5:00 PM, revealed the licensed staff should have measured the liquid medication, that called for a smaller dose than five (5) ml, with a small syringe so the amount of the medication would be accurate. She stated not ensuring an accurate dose of medication was administered to a resident could place the resident at risk for harm.	F 332			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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 371	<p>Continued From page 9</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of the facility's policy and procedures, it was determined the facility failed to prepare food under sanitary conditions. The dietary staff failed to clean the thermometer in between taking the temperature of each food item prior to service. Additionally, the facility failed to ensure the staff's hands were washed and gloves were changed after handling items in the kitchen, and then handling food.</p> <p>A review of the facility's Census and Condition, dated 10/16/12, revealed 52 out of 55 residents received their meals from the kitchen.</p> <p>Findings include:</p> <p>1. A review of the facility's Checking Temperatures of Meals policy and procedure, not dated, revealed the policy and procedure did not address the cleaning of the thermometer in between obtaining temperatures of each food item.</p> <p>Observation of the dietary staff taking food</p>	F 371	<p>1. The dietary employee was educated regarding the appropriate procedure for taking food temperatures including the cleaning of the thermometer before and after taking temperatures for each item on 10/16/12. All residents who receive food from the dietary department have the potential to be affected by this practice. Systemic Changes and Measures: 10/30/12 in-service education was provided to dietary employees by the dietary manager regarding checking food temperatures. Every dietary employee has return demonstrated proficiency in checking food temperatures. Meals Policy and Procedure was updated to include the cleaning of the thermometer in between obtaining the temperature of each food item. Monitor Performance: An orientation checklist will be developed which will include cleaning of thermometers and proper procedure for obtaining food temperatures. The checklist will be signed upon completion by the new dietary employees and trainer indicating that proficiency has been attained. The dietary manager will randomly monitor and inspect meal service weekly and at various times to ensure the policy is followed regarding taking food temperatures. Quarterly education will be conducted by the Dietary Manager to ensure dietary employees remain compliant with the policies.</p>	11/30/12
-------	---	-------	---	----------

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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 371	<p>Continued From page 10</p> <p>temperatures, on 10/17/12 at 11:45 AM, revealed the dietary staff did not clean the thermometer before or after inserting the thermometer into each food item.</p> <p>Interview with the Dietary Manager, on 10/16/12 at 12:15 PM, revealed staff should clean the thermometer with an alcohol swab before and after inserting the food into each food item.</p> <p>2. A review of the facility's Handwashing, Drying Hands and Changing Gloves Before and While Serving Food policy and procedure, not dated, revealed gloves will be worn and changed after each task, before and during food preparations and during tray lines, and as needed to prevent cross contamination.</p> <p>Observation of the tray line, on 10/19/12 at 11:55 AM, revealed the Dietary Aide obtained a bowl from the microwave and touched the microwave handle, touched the oven handle to obtain chicken patties, and handled plastic tray cards without changing her gloves and washing hands prior to returning to the tray line where she placed pork chops, chicken patties and rolls on the residents' plates with her gloved hands.</p> <p>Interview with the Dietary Manager, on 10/16/12 at 12:15 PM, revealed the Dietary Aide should have removed her gloves and washed her hands prior to returning to the tray line to handle food after touching the oven handle, microwave handle and handling tray cards.</p>	F 371	<p>2. The dietary employee was educated regarding the appropriate procedure for changing gloves before and while serving food in order to prevent cross contamination on 10/16/12. All residents who receive food from the dietary department have the potential to be affected by this practice. Systemic Changes and Measures: 10/30/12 in-service education was provided to dietary employees by the dietary manager regarding appropriate procedures for changing gloves before and while serving food and after each task in order to prevent cross contamination as outlined in the Handwashing, Drying Hands and Changing Gloves Before and While Serving Food Policy and Procedure. Every dietary employee has return demonstrated proficiency in changing gloves before and while serving food and after each task in order to prevent cross contamination. Monitor Performance: An orientation checklist will be developed which will include the Handwashing, Drying Hands and Changing Gloves Before and While Serving Food Policy and Procedure. The checklist will be signed upon completion by the new dietary employees and trainer indicating that proficiency has been attained. The dietary manager will randomly monitor and inspect meal service weekly and at various times to ensure the policy is followed consistently. Quarterly education will be conducted by the Dietary Manager to ensure dietary employees remain compliant with the policies.</p>	11/30/12
-------	---	-------	---	----------

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

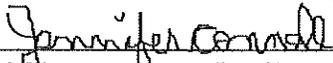
PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
--	--

(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: 1967.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 21 smoke detectors and 21 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/16/12 through 10/17/12. HAWS Memorial Nursing and Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty (60) beds with a census of Fifty-Three (53) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	1/14/13

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

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 025 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure four (4) smoke barriers were sealed around wires extending through the smoke barriers. This deficiency was cited on the survey last year on 07/07/11.	K 025	Correction: Open areas in the fire barrier have been sealed with caulking. An additional inspection was conducted by the Maintenance Supervisor to confirm all open areas have been sealed. Specific measures to ensure violation does not recur: Monthly inspections will be conducted by the Maintenance supervisors or designee to ensure the caulking remains intact and to inspect the fire barrier for additional caulking needs. The Administrator will review the Maintenance checklist monthly for compliance.	11/30/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observations, on 10/16/12 between 2:00 PM and 3:00 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed the smoke partitions, extending above the ceiling located throughout the facility, were penetrated by wires. Further observation revealed the fire wall next to the therapy area had a large hole drilled through it with no sealant.</p> <p>Interview, on 10/16/12 between 2:00 PM and 3:00 PM with the Maintenance Supervisor, revealed he was unaware of the penetrations in the smoke barriers but he did reveal the facility had ran new cable recently.</p> <p>Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware of the penetrations in the smoke barriers. The facility followed the plan of correction but the time of the checks had expired with no problems found. The facility had recently placed new data cables throughout which caused the penetrations.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <p>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</p>	K 025		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WNC _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 3 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The	K 029	Since 1970, the doors in this facility have passed all fire inspections. This is the first citation after years of compliance with life safety code. Correction: Either automatic door closers or magnetic locks will be installed on the identified doors or wired into the fire alarms system respectively. Specific measure to ensure violation does not recur: During fire drills the doors are checked to ensure magnetic locks release properly. The doors on which magnetic locks are installed and the self closing doors will be added to the quarterly inspection checklist. The Administrator will review the quarterly checklist for compliance. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.	11/30/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 029	<p>Continued From page 4</p> <p>deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure twelve (12) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p> <p>Observation, on 10/17/12 between 9:04 AM and 10:30 AM with the Maintenance Supervisor and Environmental Services Supervisor, revealed:</p> <ol style="list-style-type: none"> 1) The central supply office did not have a door closer installed. 2) The medical records office did not have a door closer installed. 3) The soiled linen on the back hall did not have a door closer installed. 4) The stock room did not have a door closer installed. 5) The activities office did not have a door closer installed. 6) The laundry door was propped open with an unapproved magnet device not on the fire alarm. 7) The therapy area cross-corridor doors were propped open with an unapproved magnet device not on the fire alarm. 8) The dry storage room in the kitchen did not have a door closer installed. 9) The housekeeping closet on the east hall did not have a door closer installed. 10) The business office did not have a door closer installed. 11) The yoga office did not have a door closer installed. 12) The copy room did not have a door closer 	K 029			

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	<p>Continued From page 5 installed.</p> <p>Any room larger than 50 ft2 with substantial combustible material must have a door that resists the passage of smoke and a closing device.</p> <p>Interview, on 10/17/12 between 9:04 AM and 10:30 AM with the Maintenance Supervisor, revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.</p> <p>Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware the listed rooms were considered hazardous storage areas, as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall</p>	K 029		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 6 include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed	K 038		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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	<p>Continued From page 7</p> <p>egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure six (6) exits were properly locked at the facility.</p> <p>The findings include:</p> <p>Observation, on 10/16/12 between 2:30 PM and 4:15 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed all egress doors were locked at the facility with the only way to exit was to enter a code. The code was not posted at the exits.</p> <p>Interview, on 10/16/12 between 2:30 PM and 4:15 PM with the Maintenance Supervisor he was unaware the doors were required to have delay to open the doors if they were going to be left in the locked position.</p> <p>Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware the doors were not properly locked at the facility as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress</p>	K 038	<p>The existing egress doors in this facility have consistently passed all life safety code requirements.</p> <p>Correction: All keypads to the egress doors will be programmed to enable door release mechanism, so that after pressing the door release bar for 15 seconds the door will open at each exit door. At each exit door, release notification will be posted for emergency egress. To ensure the violation will not recur: The door release mechanism for emergency egress will be added to the quarterly inspection checklist to ensure proper operation. The Administrator will review the quarterly checklist for compliance.</p> <p>It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.</p>	11/30/12	

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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	<p>Continued From page 8</p> <p>locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate</p>	K 038			

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 9 an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 046 SS=F	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on interview and facility record review, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure they conducted monthly lighting checks and an annual emergency lighting test for 90 minutes.	K 046	Correction: The emergency lights will be tested for one and one half hours semiannually. Testing of the emergency lights will be added to the Maintenance inspection checklist. The Administrator will review the checklist for compliance. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.	11/30/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 046	<p>Continued From page 10</p> <p>The findings include:</p> <p>Observation and record review, on 10/16/12 at 3:30 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed that the emergency lights, with battery backup, located throughout the facility had not been tested for 1-1/2 hours within the last year. Further observation revealed two checks of the battery powered lights conducted in February and June of 2012.</p> <p>Interview, on 10/16/12 at 3:30 PM with the Maintenance Supervisor, revealed he was unaware the lighting had to be tested annually for 1-1/2 hours. Further interview revealed the Fire Marshall had stated to keep a record of the monthly checks on the battery powered lighting.</p> <p>Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware the proper testing of the battery powered lighting had not been completed, as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than</p>	K 046		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 046	Continued From page 11 0.06 ft-candle (0.6lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD	K 046		
K 047 SS=D	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments,	K 047	An Exit and Directional Sign does exist approximately 20 feet from the Exit door which has passed Life Safety Code inspections since 2009. Correction: On 10/30/12 the facility electrician installed an additional Exit Sign directly over the Exit door. To ensure the violation does not recur: The Maintenance Supervisor will visually inspect all exit doors during monthly rounds. This Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not. It is not true that this Administrator "revealed she had not had any Life Safety code training, the facility does review the top 15 deficiencies throughout the state to try to stay in compliance." This Administrator does not understand where the alleged dialogue originated because at no time was it stated that this method is how we attempt to maintain compliance.	11/30/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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 047	<p>Continued From page 12</p> <p>twenty-four (24) residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure the exit path at the west lobby exit was clearly marked.</p> <p>The findings include:</p> <p>Observation, on 10/16/12 at 3:00 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed the exit door at the west lobby area did not have an exit sign placed above the door.</p> <p>Interview, on 10/16/12 at 3:00 PM with the Maintenance Supervisor he was unaware the door must have an exit sign placed above it.</p> <p>Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware the door at the west lobby was required to have an exit sign. The Administrator revealed she had not had any Life Safety Code training, the facility does review the top 15 deficiencies throughout the state to try to stay in compliance.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.</p>	K 047		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 050	<p>Continued From page 13</p> <p>varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times and failed to conduct a drill for 2nd and 3rd shift for the 3rd quarter of 2012. This deficiency was cited on the survey last year on 07/07/11.</p> <p>The findings include:</p> <p>Fire Drill review, on 10/16/12 at 3:00 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed the fire drills were not being conducted at random times on all shifts. Fire drills on first shift were conducted routinely between 8:10 AM and 9:10 AM, and third shift routinely between 5:30 AM and 5:45 AM.</p>	K 050	<p>Correction: A structured timetable will be established through December 2013. Specific dates and times will be set up in advance to ensure drills are conducted at random times and dates including weekends. The Administrator will conduct monthly audits of the fire drill records to ensure reconciliation with the timetables.</p>	11/30/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 050	Continued From page 14 Interview, on 10/16/12 at 3:00 PM with the Maintenance Supervisor, revealed he was unaware the fire drills were not being conducted as required. The Maintenance Supervisor was unaware of the time separation on each shift to consider the times unexpected. Further interview revealed he was unaware the facility missed the 2nd and 3rd shift fire drills during the 3rd quarter. Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she did not review the fire drills monthly as stated on the plan of correction from the previous survey. She was unaware the drills were missed during 3rd quarter and the times were not varied. This is a repeat deficiency. Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050			
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052			

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 052	Continued From page 15 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure twenty-one (21) smoke detectors at the facility were properly tested at least once in the last two years. The findings include: Record review, on 10/16/12 at 3:00 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed a smoke detector sensitivity test had not been performed at the facility. The paperwork from the fire alarm inspections showed a N/A on the space provided for the date of the last test. Smoke detectors must be tested according to NFPA 72 (1999 edition) to ensure their reliability. Interview, on 10/16/12 at 3:00 PM with the Maintenance Supervisor he was unaware the facility did not have a current sensitivity test on all fire alarm smoke detectors. He stated that when the company came to do the test he was under the assumption all detectors were tested.	K 052	Correction: R. Carr and Associates will conduct sensitivity tests on each smoke detector. A running schedule will be maintained that alerts the Administrator and Maintenance Supervisor when it is time to conduct future tests, i.e. every two years. The Administrator will ensure the test is scheduled on or before 11/30/2014. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.	11/30/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 052	Continued From page 16 Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware the proper testing of the smoke detectors had not been completed as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training. Reference: NFPA 72 (1999 edition) 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:	K 052		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 052	Continued From page 17 (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 052		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 056	<p>Continued From page 18</p> <p>installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure all closets in the resident rooms had sprinkler protection.</p> <p>The findings include:</p> <p>Observation, on 10/17/12 between 9:04 AM and 10:30 AM with the Maintenance Supervisor and Environmental Services Supervisor, revealed no resident closet in the facility had proper sprinkler protection.</p> <p>Interview, on 10/17/12 between 9:04 AM and 10:30 AM with the Maintenance Supervisor</p>	K 056	<p>Since 1970, the resident closets in this facility have passed all fire inspections. This is the first citation after years of compliance with life safety code. Correction: The enclosures and barriers above the closets as well as the top shelf in the closets currently restricting the sprinkler flow will be removed and left open. With this area open, if activated, the sprinkler flow will saturate contents inside the closets. All resident room closets will be remedied by the completion date and as such it will be impossible for this same violation to recur. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.</p>	12/21/12	

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 056	<p>Continued From page 19</p> <p>revealed he was not aware that the resident closets did not have proper sprinkler protection.</p> <p>Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware the resident closets in the facility must be sprinkler protected as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p>	K 056		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure valves located in the facility sprinkler system were electronically supervised by a tamper switch in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure the attic water control valve was supervised on the sprinkler system.</p> <p>The findings include:</p> <p>Observation, on 10/16/12 at 4:15 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed the sprinkler system had a valve to the attic sprinklers that was not monitored electronically. This valve was not equipped with a tamper switch, but was secured with chains. The observation was confirmed with the Maintenance Supervisor.</p> <p>Interview, on 10/16/12 at 4:15 PM with the Maintenance Supervisor, revealed he was unaware all valves leading to the sprinkler system</p>	K 061	<p>Correction: On 10/17/12 a tamper switch was installed by Key Fire Protection. The valve that was not monitored electronically will be wired into the fire alarm panel by R. Carr and Associates. To ensure compliance: The tamper switch will be evaluated for proper working condition during quarterly sprinkler system tests by Key Fire Protection. The valve enhancements will be monitored annually by R. Carr and Associates. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.</p>	11/30/12	

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 061	Continued From page 21 must be electronically supervised. Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware the sprinkler valves must be electronically monitored as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training. Reference: NFPA 101 (2000 Edition). 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 062	Continued From page 22 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure the inside of the sprinkler piping and the gauges on the sprinkler riser were inspected every five (5) years. The findings include: Observation and record review, on 10/16/12 at 3:15 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed the facility failed to provide documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last 5 years. Interview, on 10/16/12 at 3:15 PM with the Maintenance Supervisor he was not aware the gauges on the sprinkler riser had to be calibrated or replaced once every 5 years. Observation and record review, on 10/16/12 at 4:10 PM with the Maintenance Supervisor and Environmental Services Supervisor, revealed the sprinkler system had no internal inspection within the last 5 years. Further observation of the records revealed last interior pipe was unknown. Interview, on 10/16/12 at 4:10 PM with the	K 062	Correction: On 10/20/12 Key Fire Protection installed new gauges on the sprinkler riser. The sprinkler system will be examined internally for obstructions by Key Fire Protection. To ensure the violation does not recur: both the calibration and/or replacement of the gauges and the examination for internal obstructions of the sprinkler system will be conducted every five years. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.	12/15/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 062	<p>Continued From page 23</p> <p>Maintenance Supervisor, revealed he was unaware the internal sprinkler piping was to be inspected once every five (5) years. He revealed he relied on his vendors to keep the facility in compliance.</p> <p>Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware of the five (5) year services on the sprinkler system were not performed, as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p>	K 062		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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 062	<p>Continued From page 24</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <table border="1"> <thead> <tr> <th>Item</th> <th>Activity</th> <th>Frequency</th> <th>Reference</th> </tr> </thead> <tbody> <tr> <td>Gauges (dry, preaction deluge systems)</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>2-2.4.2</td> </tr> <tr> <td>Control valves</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>Table 9-1</td> </tr> <tr> <td>Alarm devices</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.6</td> </tr> <tr> <td>Gauges (wet pipe systems)</td> <td>Inspection</td> <td>Monthly</td> <td>2-2.4.1</td> </tr> <tr> <td>Hydraulic nameplate</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.7</td> </tr> <tr> <td>Buildings</td> <td>Inspection</td> <td>Annually (prior to freezing weather)</td> <td>2-2.5</td> </tr> <tr> <td>Hanger/seismic bracing</td> <td>Inspection</td> <td>Annually</td> <td>2-2.3</td> </tr> <tr> <td>Pipe and fittings</td> <td>Inspection</td> <td>Annually</td> <td>2-2.2</td> </tr> <tr> <td>Sprinklers</td> <td>Inspection</td> <td>Annually</td> <td>2-2.1.1</td> </tr> <tr> <td>Spare sprinklers</td> <td>Inspection</td> <td>Annually</td> <td>2-2.1.3</td> </tr> <tr> <td>Fire department connections</td> <td>Inspection</td> <td>Table 9-1</td> <td></td> </tr> <tr> <td>Valves (all types)</td> <td>Inspection</td> <td>Table 9-1</td> <td></td> </tr> <tr> <td>Alarm devices</td> <td>Test</td> <td>Quarterly</td> <td>2-3.3</td> </tr> <tr> <td>Main drain</td> <td>Test</td> <td>Annually</td> <td>Table 9-1</td> </tr> <tr> <td>Antifreeze solution</td> <td>Test</td> <td>Annually</td> <td>2-3.4</td> </tr> </tbody> </table>	Item	Activity	Frequency	Reference	Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2	Control valves	Inspection	Weekly/monthly	Table 9-1	Alarm devices	Inspection	Quarterly	2-2.6	Gauges (wet pipe systems)	Inspection	Monthly	2-2.4.1	Hydraulic nameplate	Inspection	Quarterly	2-2.7	Buildings	Inspection	Annually (prior to freezing weather)	2-2.5	Hanger/seismic bracing	Inspection	Annually	2-2.3	Pipe and fittings	Inspection	Annually	2-2.2	Sprinklers	Inspection	Annually	2-2.1.1	Spare sprinklers	Inspection	Annually	2-2.1.3	Fire department connections	Inspection	Table 9-1		Valves (all types)	Inspection	Table 9-1		Alarm devices	Test	Quarterly	2-3.3	Main drain	Test	Annually	Table 9-1	Antifreeze solution	Test	Annually	2-3.4	K 062		
Item	Activity	Frequency	Reference																																																																	
Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2																																																																	
Control valves	Inspection	Weekly/monthly	Table 9-1																																																																	
Alarm devices	Inspection	Quarterly	2-2.6																																																																	
Gauges (wet pipe systems)	Inspection	Monthly	2-2.4.1																																																																	
Hydraulic nameplate	Inspection	Quarterly	2-2.7																																																																	
Buildings	Inspection	Annually (prior to freezing weather)	2-2.5																																																																	
Hanger/seismic bracing	Inspection	Annually	2-2.3																																																																	
Pipe and fittings	Inspection	Annually	2-2.2																																																																	
Sprinklers	Inspection	Annually	2-2.1.1																																																																	
Spare sprinklers	Inspection	Annually	2-2.1.3																																																																	
Fire department connections	Inspection	Table 9-1																																																																		
Valves (all types)	Inspection	Table 9-1																																																																		
Alarm devices	Test	Quarterly	2-3.3																																																																	
Main drain	Test	Annually	Table 9-1																																																																	
Antifreeze solution	Test	Annually	2-3.4																																																																	

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 062	Continued From page 25 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the installed fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure the fire extinguishers in the facility had their six (6) year maintenance. Findings include:	K 064	Correction: On 10/19/12 Premier Fire Extinguisher Company conducted the hydrostatic test of the fire extinguishers identified in need of testing. A schedule of each fire extinguisher will be made indicating when each fire extinguisher is due. The schedule will be monitored quarterly by the Maintenance Supervisor and any extinguisher in need of testing will be completed on or before the due date. The Administrator will monitor the extinguisher schedule for compliance. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.	11/30/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 064	<p>Continued From page 26</p> <p>Observation, on 10/17/12 at 10:10 AM with the Maintenance Supervisor and Environmental Services Supervisor, revealed a fire extinguisher in the north front hall and one in the west hall with the last six (6) year maintenance performed in June of 2005.</p> <p>Interview, on 10/17/12 at 10:10 AM with the Maintenance Supervisor, revealed the facility was not aware the portable fire extinguishers had not been serviced properly, by their extinguisher service company.</p> <p>Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware the proper testing of the fire extinguishers had not been completed as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training.</p> <p>Actual NFPA Standard: NFPA 10, 4-4.3*. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.</p> <p>Exception: Non-rechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture.</p> <p>Non-rechargeable halon agent fire extinguishers</p>	K 064		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 064	Continued From page 27 shall be disposed of in accordance with 4-3.3.3. Actual NFPA Standard: NFPA 10, 4-4.4*. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service. Actual NFPA Standard: NFPA 10, 4-4.4.1*. Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. by 3 1/2 in. (5.1 cm 8.9 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information: (a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch (b) Name or initials of person performing the maintenance and name of agency performing the maintenance Actual NFPA Standard: NFPA 10, 4-4.4.2*. Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation	K 064			

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(X4) IO 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 064	Continued From page 28 such as is done by a hand punch. Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999. Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.	K 064			
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, twenty-four (24) residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure a couch and chairs were properly stored out of the corridor when not in use. The findings include: Observation, on 10/17/12 at 10:00 AM with the Maintenance Supervisor and Environmental Services Supervisor, revealed a couch and two (2) chairs in the exit corridor by therapy.	K 072	Correction: On 11/8/12 a request for a waiver as allowed per changes to the NFPA, LSC 2012 edition was sent to CMS by the Administrator. This waiver will allow a high quality of life for our residents to continue enjoying the lobby area "exit corridor" and the furniture. The furniture will be permanently affixed to the wall as required by LSC sections 18/19.2.3, and more specifically the requirements at 18/19.2.3.4. To ensure continued compliance: Housekeeper Supervisor on rounds will ensure furniture remains affixed to the wall. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.	12/21/12	

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 072	Continued From page 29 Interview, on 10/17/12 at 10:00 AM with the Maintenance Supervisor, revealed the facility had the area set up as a lounge area for the residents. He was unaware the furniture could not be in the exit corridor when not in use. Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware the furniture could not be in the therapy area lobby as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training.	K 072		
K 076 SS=D	Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	Correction: In facility Oxygen storage will be relocated and will be limited to less than 3,000 cu. ft. The new location ensures five feet clearance from combustible items and meets the one-hour separation requirement. To ensure the violation will not recur: The employees will be educated regarding the oxygen storage requirements. The maintenance employees will perform compliance rounds at least weekly and more often as needed. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.	12/8/12

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 076	Continued From page 30 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, no residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored 5 feet away from any combustibles. The findings include: Observation, on 10/17/12 at 9:04 AM with the Maintenance Supervisor and Environmental Services Supervisor, revealed fifteen (15) oxygen tanks in the storage room on the back north hall. The oxygen tanks were being stored within five (5) feet of combustible items. Interview, on 10/17/12 at 9:04 AM with the Maintenance Supervisor, revealed he had just checked the storage room that morning and verified there were not over twelve (12) e-cylinder tanks stored in the storage room. Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was aware of how many tanks could be stored in the storage room but was unaware of who added the tanks to the room. She relies on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training.	K 076		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 076	Continued From page 31 Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 147		

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 147	<p>Continued From page 32</p> <p>determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure multi-plug adapters and extension cords were being used properly.</p> <p>The findings include:</p> <p>Observations, on 10/17/12 between 9:04 AM and 10:30 AM with the Maintenance Supervisor and Environmental Services Supervisor, revealed:</p> <ol style="list-style-type: none"> 1) An oxygen concentrator and a mini-nebulizer were plugged into a multi-plug adapter located in room# 201. 2) A bed, feeding pump, and an oxygen concentrator were plugged into a multi-plug adapter located in room# 101. 3) A bed was plugged into a multi-plug adapter located in room# 302. 4) A bed and an air mattress were plugged into a multi-plug adapter located in room# 306. 5) A bed was plugged into a multi-plug adapter located in room# 310. 6) A hydrocollator was plugged into a standard plug in the therapy area. 7) An extension cord was plugged into a power strip above the ceiling next to the MDS office that went to another power strip which controlled the magnetic locks on the egress door next to the lobby area in the corridor. 8) A power strip was plugged into another power strip in the sprinkler riser room that controlled the satellite call system. 	K 147	<p>Correction: On 10/16/12 and 10/18/12 the facility electrician hard wired the magnetic locks to the egress door next to the lobby via a conduit. On these same dates the electrician properly hard wired a receptacle for the satellite system. The electrician will install additional hard wired receptacles in rooms 201, 101, 302, and 306. In room 310 the multi-plug adapter has been removed. To ensure compliance: Weekly rounds by maintenance or housekeeping supervisor will be made to ensure each resident room has enough receptacles to meet the medical and personal electrical requirements. Employees will be educated regarding the electrical requirements and the proper channels for reporting increased need for receptacles. It was never articulated that this Administrator "relied on the Maintenance Supervisor for Life Safety Code"; the statement cited under findings is not true. This Administrator takes full responsibility for ensuring that the Maintenance Supervisor understands his job requirements. Further clarification is warranted as this Administrator did not state that "she had not had any Life Safety Code training", but rather in response to the question as to whether or not the Maintenance Supervisor had any Life Safety Code training this Administrator responded that he had not.</p>	12/8/12
-------	--	-------	--	---------

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2012
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 33 Interview, on 10/17/12 between 9:04 AM and 10:30 AM with the Maintenance Supervisor, revealed he was unaware of what could be plugged into a power strip and a multi-plug adapter. Interview, on 10/17/12 at 11:00 AM with the Administrator, revealed she was unaware of what could be properly plugged into a multi-plug adapter as she relied on the Maintenance Supervisor for Life Safety Code. The Administrator revealed she had not had any Life Safety Code training. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D 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.	K 147			