

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/16/2012
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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MADISONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  An annual recertification survey was conducted on 02/14/12 through 02/16/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E" with the facility having an opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F 157  It is the policy of NHC Madisonville to immediately notify the resident, attending physician, and responsible party, pertaining to significant changes in a resident's physical, mental, or psychosocial status. The notifications of physician and responsible party will occur when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status ( for example, a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications) ; a need to alter treatment significantly (for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment); or a decision to transfer or discharge the resident from the facility. It is the policy of the facility to notify the resident and the resident's responsible party in the event of a room change or a change in roommate assignment.	

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

TITLE

(X6) DATE

*Danny Belman*

*adm*

3-9-12

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

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NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, MADISONVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>419 NORTH SEMINARY ST MADISONVILLE, KY 42431</b>	
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F 157	Continued From page 1  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure immediate notification of the physician, for one resident (#4), in the selected sample of eighteen residents. Resident #4 experienced a change in medical condition which necessitated medical intervention. Resident #4's lab was drawn on 12/30/11 which revealed a low Potassium level of 2.9. A report was faxed to the physician on 12/30/11; however, there were no further attempts to notify the physician regarding the resident's change in condition. The physician was not made aware of the low Potassium level until 01/04/12.  The findings include:  A review of the facility's policy/procedure, "When to Call the Physician Immediately" dated 01/09/10, revealed the resident's physician was to be notified of any abnormal or critical lab values.  A record review revealed Resident #4 was admitted to the facility on 11/21/11 with diagnoses to include Chronic Ischemic Heart Disease, Cerebrovascular Disease and Aortic Aneurysm.  A review of laboratory results, dated 12/30/11, revealed Resident #4's Potassium level was 2.9 (low)(normal range 3.5-5.1), and written	F 157	Protocol and procedures that meet the Federal requirements are in place relating to the immediate notification of resident, physician, and responsible party to changes in resident condition. This process includes the urgency and the method of notification. The immediate physician notification is made upon the professional judgment of the licensed nurse according to accepted standards of medical and nursing practice that reflect the Federal requirement.  Resident #4 had orders in place dated 1/4/2012 that reflected a change in the residents care based on the laboratory report of 12/30/2011.  A 100% audit was conducted on 02-22-12 to review laboratory testing completed in the past 30 days to determine if any other residents were affected. No other residents were affected.  In-service education was provided to all licensed nursing staff by the DON on March 6th and 7 <sup>th</sup> 2012 relating to immediate physician notification and patient status changes as well as abnormal and critical laboratory reports.  In addition, all licensed staff was educated on the process in the event the attending physician does not respond timely. There were no changes made to facility policy as the policy reflects the regulatory requirement. The content of the in-service addressed immediate physician notification.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 157	Continued From page 2 documentation on the laboratory report indicated staff faxed the report to the attending physician's office.  A review of the physician's order, dated 01/04/12, revealed "Potassium 20 meq by mouth twice a day for three days, then Potassium 20 meq once a day thereafter."  An interview with Registered Nurse (RN) #1, on 02/16/12 at 4:00 PM, revealed she expected the staff to immediately contact Resident #4's attending physician about the resident's low potassium level on 12/30/11, which necessitated a change in the resident's care. RN #1 stated she did not consider faxing the report to the attending physician without a follow-up phone call.  An interview with the Director of Nursing (DON), on 02/16/12 at 10:30 AM, revealed she considered Resident #4's Potassium level of 2.9 to be a critical lab value result considering the resident's debilitated state. She would have expected the staff to contact the attending physician immediately, by phone, on 12/30/11.	F 157	The monitoring of lab test results will be the responsibility of the Director of Nursing and the nurse management team. A lab tracking log was implemented to track abnormal and alert lab values. The tracking form also includes physician notification.  The Director of Nursing will monitor compliance of physician notification of abnormal lab results through the Quality Assurance Process. The DON will review physician notification of abnormal lab values monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be continued by the DON or as directed by the Quality Assurance Committee.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F 315  It is the policy of NHC Madisonville to ensure that residents receive appropriate perineal care in accordance with the facility's policy/procedure.  Certified Nurse Aide #1 was educated and counseled regarding the policy and procedure for providing proper pericare on 2/15/2012. C.N.A. #1 was able to return demonstrate proper perineal care.	3-29-12 Per Director, Adm. (Cm)  3-29-12	

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F 315	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure that one resident (#10) in the selected sample of eighteen residents, received appropriate perineal care in accordance with the facility's policy/procedure.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Perineal Care," undated, revealed "use washcloth with soap and water to wipe the perineal area. Separate the labia. In one even stroke, wash the sides of the labia, then wash down the middle. Use a new wipe for each stroke, then discard."</p> <p>A record review revealed Resident #10 was admitted to the facility on 12/06/10 with diagnoses to include Cerebrovascular Accident with Right-sided weakness, Muscle Weakness, Dementia, Dysarthria and Cerebral Atherosclerosis.</p> <p>A review of the "Patient Care Plan," dated 12/16/11, revealed to provide personal hygiene care after all eliminations.</p> <p>An observation of personal hygiene and perineal care, on 02/15/12 at 8:35 AM, revealed Certified Nurse Aide (CNA #1) used the same washcloth to provide personal hygiene and perineal care throughout the entire process.</p>	F 315	<p>All nursing staff was in-serviced on the facility policy/procedure for proper perineal care on 3/6/2012 and 3/7/2012 by the Director of Nursing. One on one observation of all nursing staff performing perineal care will be completed by 3/9/2012.</p> <p>All remaining residents are protected as a result of the education, instruction, and observation given to 100% of the direct care staff. Education and observations will be completed by March 9, 2012.</p> <p>The monitoring of perineal care will be the responsibility of the Director of Nursing and the nurse management team. Observations of perineal care will be randomly done by the licensed nursing staff weekly x 4 weeks and then monthly x 3 months.</p> <p>The Director of Nursing/designee will monitor compliance of perineal care through random audits monthly x3 months beginning in March and report findings to the Quality Assurance Committee. The monitoring and in-servicing will be continued by the DON or as directed by the Quality Assurance Committee.</p>	

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F 315	Continued From page 4 An interview with CNA #1, on 02/15/12 at 8:45 AM, revealed she was aware of proper procedure for providing perineal care; however, she did not provide proper care because she was "nervous." She stated she usually used a separate washcloth for perineal care.  An interview with Registered Nurse (RN #1), on 02/15/12 at 8:55 AM, revealed she was aware that the CNA #1 completed improper perineal care. No further information was provided.  An interview with the Director of Nursing (DON), on 02/15/12 at 9:10 AM, revealed the CNA #1 did not follow the facility's protocol related to proper perineal care. No further explanation was provided.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of a facility inservice, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was prepared, distributed and served under sanitary conditions.	F 371	F 371 It is the policy of NHC Madisonville to store, prepare, distribute and serve food under sanitary conditions.  The Registered Dietitian and dietary manager gave in-service education and instruction to the dietary staff on March 5, 2012. The topics of instruction and education included the proper use of hair restraints covering the top, front, and sides of the head, the use of gloves during food preparation, the appropriate technique for holding a bowl in a sanitary manner, the instruction to fill a bowl with food without contamination, the instruction of proper hand-washing, instructions on answering the phone and hand-washing, and instructions on the use of sanitized rags.	3-29-12

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F 371	<p>Continued From page 5</p> <p>Observations of tray line preparation, on 02/14/12, revealed dietary staff was wearing a hair restraint which did not cover her hair completely. Temperatures of multiple food items were obtained by dietary staff who did not sanitize the thermometer probe between testing of each food item. Dietary staff were observed plating food, then wiping their hands on their pants, and then returned to plating food without washing or gloving their hands. Dietary staff were observed to leave the tray preparation area to answer the phone, then returned to handling food items without washing or gloving their hands. A test tray, containing a carton of milk, revealed the temperature of the milk was 52 degrees Fahrenheit (F) at the point of service.</p> <p>The findings include:</p> <p>A review of a facility's policy/procedure, "Safety &amp; Sanitation Best Practice Guidelines," undated, revealed "Cold foods will be held at 41 degrees F or lower. Temperatures will be taken and recorded every two hours on cold foods. Cold items should be left in refrigerator and pulled one tray at a time during service, if possible, to help maintain temperatures."</p> <p>A review of an inservice, dated 02/04/12, revealed kitchen staff were to wash their hands before putting gloves on and after taking gloves off.</p> <p>An observation of the lunch meal tray preparation, on 02/14/12 at 10:20 AM, revealed Kitchen Staff #1's hair restraint covered the top of her head only. The front, sides and the back of her hair was not completely covered. Kitchen Staff #3 was observed to pick up bowls with an</p>	F 371	<p>In addition, the temperature of milk was addressed in the in-service. The instruction to leave the milk refrigerated until immediately prior to beginning the tray line was given. The cartons of milk will then be placed in a container of ice to ensure proper milk temperature upon leaving the dietary department.</p> <p>As a result of the in-service and education on the storage, preparation, and serving of food under sanitary conditions, all residents, staff, and visitors are protected.</p> <p>The dietary manager and registered dietitian will monitor the storage, preparation, and serving of food under sanitary conditions through daily visual observations of the tray line service and documentation of food temperatures including milk temperatures. To ensure compliance with proper temperature of foods, test trays will be conducted 3 times weekly for the next 30 days and reported to the Quality Assurance Committee. The dietary manager will also ask to visit with Resident Council to ensure residents are satisfied with food temperatures.</p> <p>The Dietary Manager will monitor compliance of the storage, preparation, and serving of food under sanitary conditions through the Quality Assurance Process. The Dietary Manager will monitor the storage, preparation, and serving of food under sanitary conditions 3 times a week for 1 month, then weekly x 1 month, and prn as</p>		

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F 371	<p>Continued From page 6</p> <p>ungloved hand, holding the bowl with her thumb inside the bowl, fill the bowl and place it on a resident's tray. Kitchen Staff #3 wiped the food that was on her hand from inside of the bowls onto her pant leg each time she filled a bowl, and continued to plate the food without washing her hands or gloving her hands.</p> <p>An observation of the supper meal, on 02/14/12 at 5:30 PM, revealed the four staff who prepared the residents' food trays were not wearing gloves. Kitchen Staff #1's hair restraint did not completely cover her hair. The front, the sides and the back of her hair was not completely covered. Kitchen Staff #1, who was handling food items was observed to answer the phone two times and return to handling food from the refrigerator. After handling the food and not washing her hands, she handed it to the kitchen staff, who were plating the food at the steam table. Observation, on 02/14/12 at 5:38 PM, revealed the milk from a test tray had a temperature of 52 degrees F. Kitchen Staff #1 stated she thought the acceptable temperature for serving milk was between 50 degrees F and 55 degrees F.</p> <p>An interview with the Director of Nursing (DON), on 02/15/12 at 5:10 PM, revealed she expected the kitchen staff to wash their hands and wear gloves, and revealed a related inservice was recently provided. Additionally, the DON stated she expected the food temperatures to be acceptable and only sanitized rags were to be utilized. She stated there was only one page listed in the policy/procedure for the kitchen and it did not address these concerns.</p> <p>An interview with the local Health Department</p>	F 371	<p>needed beginning in March 2012. The findings will be reported to the Quality Assurance Committee. The monitoring and in-service training will be continued by the Dietary Manager or as directed by the Quality Assurance Committee.</p>		

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F 371	Continued From page 7 Environmentalist, on 02/16/12 at 1:45 PM, revealed kitchen staff should wear gloves when handling or touching the interior portion of a dish or plate. It would be considered contact with a food source if the staff placed their ungloved hands/fingers inside dishes or bowls while serving food.	F 371		3-29-12
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{K 000}	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1965 Remodeled: 1972</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 02/15/12. NHC Healthcare of Madisonville was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety four (94) beds and the census was eighty three (83) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	{K 000}		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Danny Belcher* TITLE: *adm* (X6) DATE: *5-9-12*

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{K 000}	Continued From page 1 Fire)  Deficiencies were cited with the highest deficiency identified at "F" level.  A standard Life Safety Code follow-up survey was conducted on 05/03/12. NHC Healthcare of Madisonville was found not to be in compliance with the requirements for participation in Medicare and Medicaid.	{K 000}			
{K 072} SS=F	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, during the follow-up survey conducted on 05/03/12, it was determined the facility failed to ensure the deficiency cited on 02/15/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 04/30/12.  The findings include:  Observation, on 05/03/12 between 3:00 PM and 4:00 PM, with the Maintenance Director revealed linen carts, wheelchairs, lifts, cooler carts, and med carts were being stored in the corridors of the entire facility. Some examples of storage	{K 072}	K 072  It is the policy of NHC Madisonville to maintain means of egress in accordance with NFPA standards.  Overseen by the administrator, a linen cabinet and wheelchair cubby cabinet were installed in the sunshine room area and dining room for storage of linen and wheelchairs on 05-08-12. Overseen by the administrator, linen carts, lift scales and wheelchairs were removed from the hallways on 5-8-12. Overseen by the administrator, med carts are being stored behind the nursing stations, and mechanical lifts are being stored in the central bath areas effective 05-04-12.  Overseen by the administrator, in-service instructions and education regarding keeping means of egress unobstructed was completed on May 04, 2012 for direct care staff and licensed staff as to the location of storage of the linen, wheelchairs, lifts, hydration carts, and med carts.  Overseen by the Director of Nursing a Quality Assurance study of the center's compliance with keeping means of egress continuously maintained free of all obstructions was begun on 05-08-12.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  R 05/03/2012
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
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{K 072}	Continued From page 2 include the lift next to room# 101 which blocked the cross-corridor doors, a scale was in storage at the exit at room# 120, a wheelchair was stored outside the maintenance office, and a lift was stored outside room#103.  Interview, on 05/03/12 between 3:00 PM and 4:00 PM, with the Maintenance Director revealed he stated the facility was working towards doing a better job with their corridors but they were still storing items in the corridor. He also stated the linen cabinet and wheelchair cubby on their Plan of Correction was to be started in the next week.  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.	{K 072}	Hallways will be visually inspected daily x 10 days, then weekly x 6 weeks. The Director of Nursing will report findings to the Quality Assurance Committee. The studies will continue as directed by the Quality Assurance Committee.	5/8/12	

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NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, MADISONVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>419 NORTH SEMINARY ST MADISONVILLE, KY 42431</b>
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1965 Remodeled: 1972</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 02/15/12. NHC Healthcare of Madisonville was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety four (94) beds and the census was eighty three (83) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Danny Belcher</i>	TITLE <i>adm</i>	(X6) DATE <i>3-9-12</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 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 observation 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 four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds with a census of eighty three (83) on the day of the survey.  The findings include:  Observations, on 02/15/12 between 10:00 AM and 11:00 AM, with the Maintenance Director revealed the smoke partitions, extending above	K 025	It is the policy of NHC Madisonville to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards.  Fire rated attic doors were ordered and are scheduled for delivery the week of March 19, 2012. Upon delivery, installation will be completed by a local construction company.  The penetrations in the specified areas were repaired with approved materials on February 24, 2012. The repair work was completed by the Maintenance Director.  The Maintenance Director received instruction and education from the administrator regarding fire rated attic doors and penetration of smoke barriers on 03-13-12.  As a result of the replacement/repair of fire rated attic doors and penetrations in the fire compartments, the safety of residents, staff, and visitors are protected.  The monitoring of the fire rated attic doors and fire wall penetrations will be the responsibility of the Maintenance Director. The monitoring will be accomplished		

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K 025	<p>Continued From page 2</p> <p>the ceiling, located at room 100 &amp; 101, next to the patient day lounge, at room 124 &amp; 125, and at room 202 and mechanical room, were noted to have penetrations by wires, unapproved doors, or piping. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 02/15/12 between 10:00 AM and 11:00 AM, with the Maintenance Director revealed he was not aware of the penetrations or that rated doors were required in smoke barriers.</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> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration</p>	K 025	<p>through monthly inspection of the fire walls and fire rated attic doors.</p> <p>The Maintenance Director will monitor compliance of rated attic doors and penetrations in smoke barriers through the Quality Assurance Process. The Maintenance Director will visually inspect the rated attic doors and penetrations of smoke barriers monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.</p>	4-30-12	

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K 025	Continued From page 3 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 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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 exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds with a census of eighty three (83) on the day of the survey.  The findings include:  Observation, on 02/15/12 at 1:00 PM, with the Maintenance Director revealed the exit at room 120 and 121 does not have a durable surface to a public way.  Interview, on 02/15/12 at 1:00 PM, with the Maintenance Director revealed he was unaware the exit needed a durable surface to the public way.	K 038	K 038  It is the policy of NHC Madisonville to ensure exits are maintained in accordance with NFPA standards.  The exit at room 120 and 121 now has a durable surface to a public way. A forty-eight (48") concrete sidewalk was constructed the week of February 26, 2012 that connects to a public way.  The Maintenance Director received instruction and education from the administrator regarding maintenance of the durable surface on 03-13-12.  As a result of the construction of the durable surface to a public way, the safety of residents, staff, and visitors are protected.  The monitoring of the durable surface will be the responsibility of the Maintenance Director. The monitoring will be accomplished through visual inspection on a monthly basis.  The Maintenance Director will monitor compliance of the durable surface through the Quality Assurance Process. The		

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K 038	Continued From page 4	K 038	Maintenance Director will visually inspect the durable surface monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.	
K 045 SS=F	<p>Exits must have a durable surface to the public way to support wheelchairs, beds, equipment, etc., in case of an emergency situation.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition) NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/15/12 between 10:30 AM and 3:00 PM, with the Maintenance Director revealed the exterior exits numbered 7, 11, and 12, along with the laundry exit, and the exit at room 120 and 121 were equipped with a single bulb for illuminating egress path to the public way from</p>	K 045	<p>K 045</p> <p>It is the policy of NHC Madisonville to ensure exits are equipped with lighting in accordance with NFPA standards.</p> <p>An electrical contractor made the necessary repairs to exterior exits 7, 11, and 12 along with the laundry exit, and the exit at room 120 and 121. The lighting fixtures serving the exterior exits now include more than one bulb with the repairs being made the week of February 20, 2012.</p> <p>As a result of the electrical repairs being made to the exit lighting, the safety of residents, staff, and visitors are protected.</p> <p>The monitoring of the exterior exit lighting will be the responsibility of the Maintenance Director. The monitoring will be accomplished through visual inspection on a weekly basis.</p> <p>The Maintenance Director will monitor compliance of exit lighting through the Quality Assurance Process. The</p>	3-29-12

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K 045	Continued From page 5 the exit.  Interview, on 02/15/12 between 10:30 AM and 3:00 PM, revealed the Maintenance Director was unaware the lighting fixtures serving the exterior exits must include more than one bulb.  Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness.  Reference: NFPA 101 (2000 edition) Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area	K 045	Maintenance Director will visually inspect the exit lighting monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and record review, it was	K 050	It is the policy of NHC Madisonville to conduct fire drills at unexpected random times according to NFPA standards.  In-service and education was provided to the Maintenance Director by the administrator related to conducting fire drills quarterly on each shift at random times under varied conditions. The education was provided on March 13, 2012  As a result of the education and compliance with random fire drills under varied conditions the safety of residents, staff, and visitors are protected. The monitoring of the random fire drills will be the responsibility of the Maintenance Director. The monitoring will		

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K 050	Continued From page 6 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, residents, staff, and visitors. The facility is licensed for ninety four (94) beds and the census was eighty three (83) on the day of the survey.  The findings include:  Fire Drill review, on 02/15/12 at 9:18 AM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. First shift fire drills were being conducted predictably between 1:00 PM and 2:00 PM, second shift at 3:30 PM, and third shift at 6:30 AM.  Interview, on 02/15/12 at 9:18 AM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	be accomplished through visual inspection of the documentation of the random fire drills on a monthly basis  The Maintenance Director will monitor compliance of random fire drills through the Quality Assurance Process. The Maintenance Director will visually inspect documentation of random fire drills monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the	K 056	K 056  It is policy of NHC Madisonville to ensure the building has a complete sprinkler system in accordance with NFPA standards.	3-29-12	

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K 056	<p>Continued From page 7</p> <p>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 one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety four (94) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/15/12 at 1:50 PM, with the Maintenance Director revealed that the exit next to the kitchen and room 305 did not have sprinkler coverage under the porch that extends over 4' and is made of combustible material.</p> <p>Interview, on 02/15/12 at 1:50 PM, with the Maintenance Director revealed he was not aware the porch needed to be sprinkler protected.</p> <p>Observation, on 02/15/12 at 2:30 PM, with the Maintenance Director revealed standard response sprinkler heads and quick response sprinkler heads in the same compartment located</p>	K 056	<p>On February 17, 2012 a representative from a licensed sprinkler company was at the facility to review the scope of the work required to complete sprinkler coverage to the exit next to the kitchen and room 305 that extends under the porch over 4'. The repairs will be completed as soon as the work can be cycled into the sprinkler company's work schedule.</p> <p>In addition, the sprinkler company reviewed the scope of work to install quick response sprinkler heads in the same compartment of the dining room. The installation of the quick response sprinkler heads will be completed as soon as the work can be cycled into the sprinkler company's work schedule.</p> <p>As a result of installing sprinklers to the 4' overhang of the porch and installing quick response sprinkler heads to the same compartment of the dining room, the safety of residents, staff, and visitors are protected.</p> <p>The monitoring of the sprinklers to the 4' overhang of the porch and quick response sprinkler heads to the same compartment of the dining room will be the responsibility of the Maintenance Director.</p>		

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K 056	<p>Continued From page 8 in the dining room.</p> <p>Interview, on 02/15/12 at 2:30 PM with the Maintenance Director revealed he was not aware that the sprinkler heads had to have the same response time if the sprinkler heads are located in the same compartment.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception: * Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected</p>	K 056	<p>The Maintenance Director will monitor compliance of the sprinklers to the 4' overhang of the porch and quick response sprinkler heads to the same compartment in the dining room through the Quality Assurance Process. The Maintenance Director will visually inspect sprinklers to the overhang of the porch next to the kitchen and room 305 monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. In addition, a licensed sprinkler company will inspect the sprinkler system quarterly. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.</p>	4-30-12	

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NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, MADISONVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>419 NORTH SEMINARY ST MADISONVILLE, KY 42431</b>		
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K 056	Continued From page 9 throughout by an approved automatic sprinkler system.	K 056			
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>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, residents, staff and visitors. The facility is licensed for ninety four (94) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings Include:</p> <p>Observation, on 02/15/12, between 10:15 AM and 2:30 PM, with the Maintenance Director revealed sprinkler heads located throughout the facility to be covered in paint</p> <p>Interview, on 02/15/12 between 10:15 AM and 2:30 PM, with the Maintenance Director revealed he was not aware of there could be no paint on the sprinkler heads.</p> <p>Observation, and record review, on 02/15/12 between 10:15 AM and 2:30 PM, with the Maintenance Director revealed the facility had</p>	K 062	<p>K 062</p> <p>It is the policy of NHC Madisonville to maintain the sprinkler system in accordance with NFPA standards.</p> <p>On February 17, 2012 a representative from a licensed sprinkler company was at the facility to review the scope of the work required to replace the sprinkler heads covered with paint, corroded, damaged, loaded, or in the improper orientation. The replacement of the sprinkler heads covered with paint, corroded, damaged, loaded, or in the improper orientation will be completed as soon as the work can be cycled into the sprinkler company's work schedule.</p> <p>The representative from the sprinkler company checked to determine if the Star sprinkler heads in the facility were part of the recall. Any sprinkler heads found to be part of the recall would be replaced by the licensed sprinkler company. The recalled sprinkler heads will be replaced as soon as the work can be cycled into the sprinkler company's work schedule.</p> <p>In addition, the facility purchased a sprinkler head wrench on March 7, 2012 in accordance with NFPA standards.</p> <p>As a result of replacing the affected sprinkler heads, the safety of residents, staff, and visitors are protected.</p>		

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K 062	<p>Continued From page 10</p> <p>STAR E: sprinkler heads located throughout the facility and the attic that could be part of a recall. The facility failed to produce evidence that the sprinkler heads had been checked to confirm if the Star sprinkler heads in the facility were part of the recall.</p> <p>Interview, on 02/15/12 between 10:15 AM and 2:30 PM, with the Maintenance Director revealed he was not aware of the recall and did not know if the heads had been checked.</p> <p>Observation, on 02/15/12 at 1:15 PM, with the Maintenance Director revealed the facility failed to provide a sprinkler head wrench in accordance with NFPA standards.</p> <p>Interview, on 02/15/12 at 1:15 PM, with the Maintenance Director revealed they were not aware of the missing sprinkler head wrench.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical</p>	K 062	<p>The administrator presented education and in-service to the Maintenance Director related to affected sprinkler heads on March 13, 2012.</p> <p>The monitoring of the replacement of the sprinkler heads covered with paint, corroded, damaged, loaded, or in the improper orientation will be the responsibility of the Maintenance Director. In addition, the Maintenance Director will be responsible for the monitoring of any recalled sprinkler heads and the sprinkler head wrench. The monitoring will occur through visual observation of sprinkler heads on a monthly basis and quarterly inspection by a licensed sprinkler company.</p> <p>The Maintenance Director will monitor compliance of the sprinkler heads covered with paint, corroded, damaged, loaded, or in the improper orientation, recalled sprinkler heads, and the sprinkler head wrench through the Quality Assurance Process. The Maintenance Director will visually inspect sprinkler heads covered with paint, corroded, damaged, loaded, or in the improper orientation monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. In addition, a licensed sprinkler company will inspect the sprinkler system quarterly. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.</p>		

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K 062	<p>Continued From page 11</p> <p>damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for</p>	K 062		

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K 062	Continued From page 12 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.	K 062		
K 066 SS=D	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. NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover	K 066	It is the policy of NHC Madisonville to use approved ashtrays in designated smoking areas, in accordance with NFPA standards.  Approved ashtrays were installed in designated smoking areas and put in use the week of February 20, 2012. Approved ashtrays were installed at exit #'s 6, 7, 11, & 12.  As a result of installing approved ashtrays in designated smoking areas, the safety of residents, staff, and visitors are protected.  The administrator presented education and in-service to the Maintenance Director related to maintenance and upkeep of the approved ashtrays on March 13, 2012.  The monitoring of the approved ashtrays will be the responsibility of the	4-30-12

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K 066	<p>Continued From page 13</p> <p>devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety four (94) beds and the census was eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/15/12 between 11:45 AM and 2:30 PM, with the Maintenance Director revealed the ashtrays located at the entrances numbered 6, 7, 11 and 12 were not of the unapproved type. They did not have a metal container with a self-closing lid to dump ashtrays.</p> <p>Interview on 02/15/12 between 11:45 AM and 2:30 PM, with the Maintenance Director revealed he was not aware of the requirement for self-closing ashtrays.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be</p>	K 066	<p>Maintenance Director. The monitoring will occur through visual observation of the approved ashtrays on a weekly basis to ensure proper maintenance and upkeep.</p> <p>The Maintenance Director will monitor compliance of the approved ashtrays through the Quality Assurance Process. The Maintenance Director will visually inspect approved ashtrays monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.</p>	3-29-12	

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K 066	Continued From page 14 readily available to all areas where smoking is permitted.	K 066		
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds with a census of eighty three (83) on the day of the survey.  The findings include:  Observation, on 02/15/12 between 10:15 AM and 2:00 PM, with the Maintenance Director revealed a portable space heater located in the Receptionist Office, the Janitor Closet on the 200 hall, and the Sprinkler Riser room.  Interview, on 02/15/12 between 10:15 AM and 2:00 PM, with the Maintenance Director revealed they were not aware the heaters could not exceed 212°F in nonsleeping, staff, and employee areas.	K 070	K 070  It is the policy of NHC Madisonville to prohibit use of portable space heaters in accordance with NFPA standards.  Portable space heaters were removed from the Receptionist Office, the Janitor Office on the 200 Hall, and the Sprinkler riser room on February 17, 2012.  As a result of removing the portable space heaters from the Receptionist Office, the Janitor Office on the 200 Hall, and the Sprinkler riser room, the safety of residents, staff, and visitors are protected.  The administrator presented education and in-service to the Maintenance Director related to prohibiting portable space heater use on March 13, 2012.  The monitoring of the prohibiting of space heater use will be the responsibility of the Maintenance Director. The monitoring will occur through visual observation to ensure no space heaters are in use. The observations will occur on a weekly basis.  The Maintenance Director will monitor compliance of the prohibiting of space heater through the Quality Assurance Process. The Maintenance Director will visually inspect no space heater use monthly x 3 beginning in March 2012 and report findings to the Quality Assurance	

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K 070	Continued From page 15 Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.		
K 072 SS=F	Reference: NFPA 13 (1999 edition) 4-2.5.2 Valve rooms shall be lighted and heated. The source of heat shall be of a permanently installed type. Heat tape shall not be used in lieu of heated valve enclosures to protect the dry pipe valve and supply pipe against freezing. 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 five (5) of five (5) smoke compartments, residents, staff,	K 072	K 072 It is the policy of NHC Madisonville to maintain exit access in accordance with NFPA standards.  A linen cabinet and wheelchair cubby cabinet is scheduled for installation in the sunshine room area for storage of linen and wheelchairs. The med carts will be housed behind the nursing station(s) when not in use. The lifts will be housed in the central bath areas of the facility when not in use.  As a result of the scheduled installation of the linen cabinet and wheelchair cubby cabinet in the sunshine room, storage of	3-29-12	



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K 076	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety four (94) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/15/12 at 10:47 AM, with the Maintenance Director revealed there was no signage indicating full or empty oxygen tanks in the oxygen storage room.</p> <p>Interview, on 02/15/12 at 10:47 AM, with the Maintenance Director revealed he was not aware the oxygen tanks needed signage indicating full or empty.</p> <p>Reference: NFPA 99 (1999 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</p>	K 076	<p>Signage has been placed in the oxygen storage room to indicate full or empty tanks of oxygen. This was completed the week of March 5, 2012.</p> <p>As a result of placing the oxygen signage, the safety of residents, staff, and visitors are protected.</p> <p>In-service instructions and education was given to all direct care staff and licensed staff on March 13, 2012 as to the signage in the oxygen storage room indicating full and empty tanks. The administrator presented the in-service.</p> <p>The monitoring of oxygen storage signage will be the responsibility of the Maintenance Director. The monitoring will occur through visual observation of the oxygen storage room signage to ensure proper usage of the signage. The observations will occur on a daily basis.</p> <p>The Maintenance Director will monitor compliance of oxygen storage use signage through the Quality Assurance Process. The Maintenance Director will visually inspect oxygen storage room signage monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.</p>	

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K 076	Continued From page 18 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.  8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076					
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K 144  The emergency generator is inspected weekly by the Maintenance Director and exercised under load for 30 minutes weekly per NHC policy and protocol.  A visual and audible device was installed on 09-21-09 at B Hall nursing station to monitor the emergency generator. The device monitors the generator's control devices to ensure they are in the on position and the generator's battery is charged. Full annunciation could not be accomplished	3-29-12			

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	185015	A. BUILDING 01 - MAIN BUILDING 01		
		B. WING _____		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
NHC HEALTHCARE, MADISONVILLE		419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	<p>Continued From page 19</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety four (94) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/15/12 at 2:35 PM, with the Maintenance Director revealed the facility was equipped with a emergency generator. The generator is not equipped with an annunciation panel that is in a 24 hour monitored area to make staff aware of alarm conditions with the generators.</p> <p>Interview, on 02/15/12 at 2:35 PM, with the Maintenance Director revealed he was not aware the generator needed an annunciation panel to inform staff of alarm conditions of the emergency power source.</p> <p>This is a Repeat Deficiency.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section</p>	K 144	<p>due to the age of the generator. (see attached documentation)</p> <p>The monitoring device is located where monitoring can occur continuously by staff, including maintenance staff.</p> <p>By the presence of the monitoring device all patients, staff, and visitors are protected.</p> <p>The Maintenance Director presented an in-service on March 13, 2012 related to the monitoring device and the emergency generator.</p> <p>The Maintenance Director will monitor the device through visual inspection on daily rounds.</p> <p>The Maintenance Director will monitor compliance of the audible and visual device through the Quality Assurance Process. The Maintenance Director will visually inspect the visual and audible device monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/15/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, MADISONVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>419 NORTH SEMINARY ST MADISONVILLE, KY 42431</b>		
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K 144	Continued From page 20 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144			
K 147 SS=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:	K 147	It is the policy of NHC Madisonville to ensure electrical wiring is maintained in accordance with NFPA standards.  Storage in front of the electrical panels in the mechanical room on the 200 hall section was removed on February 24, 2012.	3-29-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/15/2012</b>
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K 147	<p>Continued From page 21</p> <p>Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety four (94) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 02/15/12 between 10:15 AM and 1:30 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> <li>1) Storage in front of electrical panels in the mechanical room on the 200 hall.</li> <li>2) An extension cord in use in the Bookkeeper's Office.</li> <li>3) Open electrical junction boxes were located in the attic throughout entire attic of the facility.</li> <li>4) Battery Chargers were plugged into a power strip in Central Supply Room.</li> <li>5) Hydro Collator was plugged into a standard plug, instead of the required Ground Fault Circuit Interrupter.</li> <li>6) The power strip with an 1875W rating was overloaded with a 1500W microwave and a 900W Coffee Pot adjacent to the nurses' station on the 100 hall.</li> <li>7) An extension cord was in use in the nurses' station at the end of the 200 hall.</li> </ol> <p>Interview, on 02/15/12 between 10:15 AM and 1:30 PM, with the Maintenance Director revealed he was not aware the power strips were being misused. He was also not aware of the storage in front of the electrical panels, or the open</p>	K 147	<p>The extension cord in the Bookkeeper's Office was removed on February 24, 2012.</p> <p>Covers on junction boxes located in the attic were installed the week of February 20, 2012.</p> <p>The power strip in the Central Supply room was removed the week of March 5, 2012,</p> <p>The required Ground Fault Circuit interrupter was installed for the Hydro Collator the week of March 5, 2012.</p> <p>An additional outlet was installed for the microwave and coffee pot adjacent to the nursing station on the 100 Hall the week of March 5, 2012.</p> <p>The extension cord used at the nursing station on the 200 Hall has been removed the week of March 5, 2012.</p> <p>As a result of these changes to the electrical wiring, the safety of residents, staff, and visitors are protected.</p> <p>In-service instructions and education was given to all direct care staff, licensed staff, housekeeping staff, and dietary staff on March 13, 2012 as to the changes made in the electrical wiring. The administrator presented the in-service.</p> <p>The monitoring of electrical wiring will be the responsibility of the Maintenance Director. The monitoring will occur</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/15/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, MADISONVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>419 NORTH SEMINARY ST MADISONVILLE, KY 42431</b>
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K 147	<p>Continued From page 22 junction boxes in the attic.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p>	K 147	<p>through visual observation of the electrical wiring changes to ensure compliance. The observations will occur on a daily basis.</p> <p>The Maintenance Director will monitor compliance of electrical wiring changes through the Quality Assurance Process. The Maintenance Director will visually inspect the wiring changes monthly x 3 beginning in March 2012 and report findings to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.</p>	3-29-12
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