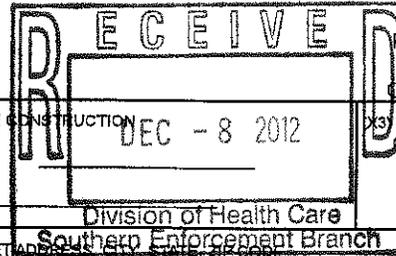


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/13/2012
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADDLARK DRIVE RICHMOND, KY 40475	
(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	F 000		
F 166 SS=D	<p>An abbreviated standard survey (KY19283, KY19287) was conducted on 11/13/12. KY19283 was substantiated with related deficient practice identified at 'D' level. KY19287 was unsubstantiated with unrelated deficiencies.</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, the facility failed to ensure prompt efforts were made to resolve grievances for one of three sampled residents (Resident #3) and four of four unsampled residents (Residents D, E, F, and G) selected for review. Interviews conducted on 11/13/12 with Residents #3, D, E, F, and G revealed facility staff did not always pass ice in a timely manner, failed to answer call lights timely, failed to honor food preferences and, on occasion, failed to serve food that was cooked properly or at the proper temperature. However, even though the residents stated they had voiced complaints/grievances about their concerns, a review of documentation and interviews revealed the facility failed to resolve the grievances or inform the residents of any actions taken related to the grievances.</p> <p>The findings include:</p>	F 166	<p>1. Resident #3, Resident D, E, F and Resident G were interviewed by the Dietary Services Manager(DSM) on 11/13/2012 to ensure all food preferences were up to date, they were immediately given fresh ice and the call light issue was discussed with each of them by the Administrator on 11/13/2012. A grievance related to all issues was completed on behalf of Resident #3, Resident D, E, F and G on 11/13/2012 by the Administrator. The Medical Director was made aware of the above concerns on 11/14/2012 by the Unit Manager (UM) with no new orders noted. No other resident was noted.</p> <p>2. Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Nurse Consultant (RNC), and DSM and UM to review all grievances from a period of 10/20/2012 through 11/30/2012 by 12/15/2012 to identify any issue with any grievance, to identify any grievance that was not completely addressed, followed up and resolved. Any issue identified will be immediately resolved.</p>	

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

*Ray C. Baker* Administrator 12/13/12

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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F 166	<p>Continued From page 1</p> <p>A review of the facility's Concern/Grievance Policy (no date given) revealed the facility employee who received a concern or grievance would be responsible to ensure a grievance form was completed. Once the form has been completed, the Administrator is to receive the form and determine which department is responsible for the concern or grievance. The department where the grievance or concern originated would have five days to communicate the resolution of the grievance or concern to the family or the resident.</p> <p>A review of the medical record revealed the facility admitted Resident #3 on 11/05/12. A Roster/Sample Matrix dated 11/13/12 revealed Resident #3 was cognitively aware.</p> <p>An interview with Resident #3 on 11/13/12 at 10:30 AM, revealed upon admission to the facility the resident informed staff that due to the resident's medical condition the resident preferred not to be served vegetables, especially cabbage, during meals. Further interview with the resident revealed although he/she was unable to recall how often, he/she had received vegetables during meal service "multiple times" and had received cabbage on three different occasions. Resident #3 stated facility staff had been made aware of the resident's food preference when the resident's food was provided and on those occasions facility staff offered another food choice.</p> <p>A group interview conducted with four alert and oriented residents (Residents D, E, F, and G) on 11/13/12 at 3:00 PM, revealed the residents had voiced concerns on numerous occasions related to ice not being passed timely, food preferences</p>	F 166	<p>All cognitive residents and at least 5 family members will be interviewed by the Social Services Director by 12/17/2012 to identify any grievance or issue that is occurring. Any issue identified will require a grievance in writing and forwarded to the Administrator and the RNC for resolution. Any grievance will be addressed immediately.</p> <p>A Resident Council Meeting will be held by the Activity Director by 12/7/2012 to identify any on going grievance related to call lights, food and /or ice pass. Any issue identified will require a grievance in writing and a copy forwarded to the RNC.</p> <p>All issues will be immediately addressed.</p> <p>3. RNC to re educate Administrator and Education Training Director (ETD) regarding the grievance process and follow up/resolution and on going monitoring by 11/15/2012.</p> <p>ETD to re educate DON/ADON/UM and facility staff regarding grievance process/follow up, resolution and on going monitoring by 12/17/2012.</p> <p>ETD to re educate all nursing staff regarding passing ice, answering call lights and not serving residents food that is on their "dislike list" by 12/17/2012.</p>		

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F 166	<p>Continued From page 2</p> <p>not being honored, staff not answering call lights timely, and meals being cold or not cooked properly. The residents stated the concern with the ice not being passed had occurred on all shifts, and their concerns with meal service occurred during the supper meal. The residents stated they had made the facility aware of their complaints but had never received a response from the facility. Resident F stated the facility's Administrator had verbally followed up on the ice not being passed on 11/13/12 (seven days after the last Resident Council Meeting had been conducted). However, according to the residents, facility staff had not attempted to resolve the issues that were expressed before 11/13/12.</p> <p>A review of the Resident Council Minutes for the month of June 2012 revealed the residents voiced concerns related to ice not being passed and meals not always hot when served to the residents. Resident Council Minutes dated 06/05/12 revealed "old business" had been discussed related to ice not being passed on all shifts but failed to identify what efforts had been made by the facility to resolve the issues.</p> <p>Although the Administrator stated in interview conducted on 11/13/12 at 4:15 PM, that a Resident Council Meeting was held in July 2012, facility staff could not locate the Resident Council Minutes for the month of July 2012 and, as a result, the minutes were not available for review.</p> <p>A review of the Resident Council Minutes dated 08/07/12 revealed staff had documented, "No new issues." However, no evidence was provided related to what the residents' issues were or what efforts had been made by the facility</p>	F 166	<p>UM to keep grievance forms at each unit beginning 12/1/2012 available to staff, family and residents to ensure they are available for anyone to complete.</p> <p>Ice pass to be completed 2 x shift beginning 11/17/2012. UM/Charge nurse to ensure this is completed. DON/ADON to randomly audit ice pass being completed as ordered 3 x weekly beginning week of 11/17/2012 x 6 weeks, then 2 weekly x 4 weeks.</p> <p>All Department Managers to audit at least 3 call lights randomly weekly x 6 weeks beginning the week of 11/25/2012 then 1 x week x 4 weeks to ensure all lights are being answered timely.</p> <p>Dietary Manager to monitor food service during tray line 2 x weekly x 4 weeks beginning the week of 12/1/2012 to ensure that no foods are served to the resident that is on their respective "dislike list".</p> <p>RNC to audit all Resident Council Meeting minutes x 3 months beginning 12/2012 to ensure all grievances are followed up on and are available.</p> <p>RNC/RDO (Regional Director of Operations) to audit at least 5 grievances monthly x 3 monthly beginning 12/2012 to ensure grievance follow up and monitoring is complete.</p> <p>SSD to interview 5 cognitive residents and 1 family member weekly x 4 weeks beginning the week of 12/17/2012 to ensure all grievances are noted and followed up.</p> <p>4. Quality Assurance Team to meet at least weekly beginning week of 12/15/2012 to review audit findings and make recommendations' meeting to be held weekly until issues resolved.</p> <p>5. Date of Compliance 12/18/2012.</p>		

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F 166	<p>Continued From page 3 to resolve the issues.</p> <p>A review of the Resident Council Minutes dated 09/04/12 revealed the residents had voiced concerns related to ice not being passed on all shifts. Further review revealed facility residents had voiced concerns related to receiving food items which were listed on their meal ticket as a dislike; however, there was no documentation of efforts made by the facility to resolve the past or present issues.</p> <p>A review of the Resident Council Minutes dated 10/09/12 revealed the residents had voiced concerns related to ice not being passed in a timely manner, and food not properly cooked. Further review of the minutes revealed residents had voiced concerns related to call lights not being answered in a timely manner. However, it could not be determined by a review of the minutes what actions would be taken and/or had been made by the facility to resolve the issues.</p> <p>A review of the Resident Council Minutes dated 11/06/12 revealed the residents had voiced concerns related to ice not being passed on all shifts, and call lights not being answered in a timely manner. However, it could not be determined by a review of the minutes what prior actions had been made by the facility to resolve the residents' concerns.</p> <p>An interview with the Activity Director on 11/13/12 at 7:40 PM, revealed she attended all Resident Council Meetings. The Activity Director stated the residents had complained of cold food, call lights not being answered timely, and food overcooked. According to the Activity Director, the residents'</p>	F 166			

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F 166	Continued From page 4 concerns that had been voiced were taken to the morning meetings with department heads and given to the department head for the appropriate department. The Activity Director also revealed the Administrator was responsible to conduct a follow-up with the residents within five days to ensure their concerns had been resolved.  An interview with the facility's Administrator on 11/13/12 at 8:00 PM, confirmed the Administrator was responsible to conduct a follow-up with the residents within five days to ensure resident concerns/grievances were resolved. The Administrator stated he had conducted a follow-up with the residents within five days after receipt of a complaint/grievance and there had not been any concerns identified. However, documentation of the follow-ups conducted by the Administrator that addressed the resolutions to the residents' concerns was not made available for review.	F 166			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policies, it was determined	F 323			

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F 323	<p>Continued From page 5</p> <p>the facility failed to ensure the residents' environment remained as free of accident hazards as possible. During initial tour of the facility on 11/13/12 at 11:15 AM, temperatures in the sink in the resident shower room on the D Unit of the facility were observed to be 118 degrees Fahrenheit. A review of the facility's policy titled "Test Water Temperatures," undated, revealed resident room water temperatures should be maintained as specified by state requirements. A review of the Kentucky Administrative Regulations at 902 KAR 20:021, Section 15.(6)(a), revealed plumbing fixtures which require hot water and which are intended for patient use shall be supplied with water which is controlled to provide a water temperature of 100 to 110 degrees Fahrenheit at the fixture.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Test Water Temperatures," which contained no date, revealed resident room water temperatures should be maintained as specified by state requirements.</p> <p>A review of the Kentucky Administrative Regulations at 902 KAR 20:021, Section 15.(6) (a), revealed plumbing fixtures which require hot water and which are intended for patient use shall be supplied with water which is controlled to provide a water temperature of 100 to 110 degrees Fahrenheit at the fixture.</p> <p>Observation of the water temperature during initial tour of the facility on 11/13/12 at 11:15 AM, revealed temperatures in the sink in the resident shower room on the D Unit were observed to be</p>	F 323	<p>F 323</p> <p>1. No resident was specifically identified. All residents have the potential to be affected. D hall shower room was immediately closed and locked. DON/ETD re educated all staff immediately on 11/13/2012 to not use the shower room and a note in writing was placed on the shower room door related to non use instructions. The Medical Director was made aware of the water temperatures on 11/13/2012 by the UM.No new orders were noted.</p> <p>2. An audit of all shower rooms and all rooms water temperature was completed by the Maintenance Director and the Administrator on 11/13/2012 to identify any temperature above 110 degrees. No other issues were identified. An audit of all showers rooms and all resident rooms was completed by the Administrator on 11/14/2012 to identify any water temperature above 110 degrees. Any issue identified was immediately addressed. All temperature logs from 10/13/2012 through 11/13/2012 were reviewed by the Administrator on 11/14/2012 to identify any water temperature above 110 degrees and to identify any area in the center that had an issue with water temperatures. Any issue identified was immediately addressed. RNC to complete a one time water temperature check with the Maintenance Director by 11/16/2012 to ensure water temperature checks are completed accurately. Any issues identified will be immediately addressed.</p>		

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F 323	Continued From page 6 118 degrees Fahrenheit. The shower room door was observed to be locked.  An interview conducted with the Maintenance Supervisor on 11/13/12 at 11:20 AM, revealed he had been unaware the water temperature was greater than 110 degrees Fahrenheit on the D Unit. The Maintenance Supervisor revealed he had checked the water temperature in the D Unit resident shower room approximately a week prior to 11/13/12 and the temperature at that time was 106 degrees Fahrenheit. The Maintenance Supervisor stated residents did not have unassisted access to the shower room on the D Hall; however, the Maintenance Supervisor acknowledged the shower room was available for resident use.  An interview conducted with the Administrator on 11/13/12 at 8:05 PM, revealed the Maintenance Supervisor submitted water temperatures once a month for review and the Administrator had not identified any concerns. The Administrator stated water temperatures should not have been greater than 110 degrees Fahrenheit in the sink of the residents' shower room.	F 323	A one time audit of all resident rooms and care areas to be completed by the Administrator and DON to identify any risks for accident /injury by 11/20/2012. Any issues identified will be immediately corrected.  3. Administrator to re educate the Maintenance Director regarding water temperature regulations, how to complete water temperature testing, when to complete water temperature testing and where to complete water temperature testing. This to be completed by 11/14/2012. Administrator to check all shower rooms water temperatures at least 5 x weekly x 6 weeks beginning 11/14/2012 to ensure all temperatures are within federal guideline limits and are not above 110 degrees. Any temperature above 110 degrees will require non use and a written sign to be placed notifying all staff and visitors not to use. This to begin 11/13/2012 and will be on going. Administrator to review water temperature logs for all areas in the center at least 3 x weekly x 6 weeks beginning the week of 11/14/2012.		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced	F 363	RDO/RNC to review water temperature logs weekly x 4 weeks to ensure all temperatures meet federal guidelines and are below 110 degrees in all shower rooms and rooms beginning 11/25/2012. SSD to interview at least 5 cognitive residents weekly x 4 weeks regarding water temperatures being comfortable beginning week of 11/25/2012. ETD to re educate staff regarding the prevention of accident and incidents, this includes water temperatures and the protocol for center to prevent accident/incidents of any kind to ensure patient safety. This will be completed by 12/17/2012.		

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F 363	Continued From page 7 by: Based on observation, interview, record review, and review of the facility's menu, it was determined the facility failed to ensure menus were followed for three unsampled residents (Residents A, B, and C). Observation of the evening meal on 11/13/12 at 6:05 PM, revealed Residents A, B, and C were eating in the main dining room. Based on observation, facility staff had served the three residents a square piece of spice cake that measured approximately one inch by one inch. A review of the facility's menu for the evening meal on 11/13/12 revealed the residents were supposed to receive a square piece of spice cake measuring two inches by three inches.  The findings include:  A review of the menu for the evening meal on 11/13/12 revealed residents who received a regular meal tray and a mechanical soft meal tray were required to receive a square of spice cake measuring two inches by three inches.  Observation of the evening meal service in the main dining room on 11/13/12 at 6:05 PM, revealed Resident A was served a regular diet, with no calorie restrictions, which contained a square piece of spice cake measuring approximately one inch by one inch. A review of the facility's roster matrix dated 11/13/12 revealed the resident had been assessed to be cognitively impaired and therefore an interview was not attempted.  Observation of the evening meal service in the main dining room on 11/13/12 at 6:05 PM,	F 363	4. Quality Assurance Team to meet at least weekly beginning week of 12/15/2012 to review audit findings and make recommendations' meeting to be held weekly until issues resolved.  5. Date of Compliance 12/18/2012.  F 363  1. Residents A, B and C were immediately offered another piece of cake that was the correct size on 11/13/2012 by the C.N.A. Medical Director was made aware of the serving size issue on 11/14/2012 by the UM and no new orders were noted.  2. A one time audit of all food served was completed by the DSM and Administrator on 11/14/2012 to identify any dietary staff who did not serve the correct portion and to ensure that food likes and dislikes were honored. Any issues identified were immediately corrected. DSM to complete a one time observation by 12/15/2012 of all dietary staff individually to identify any staff that do not know correct food servings, how to cut a piece of cake into correct serving portions and to identify any issue with serving residents foods on their dislike list. Any issue identified will be immediately corrected.	

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F 363	<p>Continued From page 8</p> <p>revealed Resident B was served a mechanical soft diet, with no calorie restrictions, which included a square piece of spice cake measuring approximately one inch by one inch. A review of the facility's roster matrix dated 11/13/12 revealed the resident had been assessed to be cognitively impaired and an interview was not attempted.</p> <p>Observation of the evening meal service in the main dining room on 11/13/12 at 6:05 PM, revealed Resident C was served a mechanical soft diet, with no calorie restrictions, which also included a square piece of spice cake measuring approximately one inch by one inch. A review of the facility's roster matrix dated 11/13/12 revealed the resident had been assessed to be cognitively impaired and an interview was not attempted.</p> <p>An interview conducted with Cook #1 on 11/13/12 at 7:00 PM, revealed she was responsible for serving the cake to residents at the evening meal on 11/13/12. Cook #1 stated she had not measured the cake prior to cutting it. The Cook stated she had misjudged the size of the pieces and had cut the pieces of cake too small.</p> <p>An interview conducted with the Dietary Manager on 11/13/12 at 6:10 PM, revealed residents were supposed to have received a two-inch by three-inch square piece of spice cake for the evening meal as indicated in the menu. The Dietary Manager stated staff was expected to review the menu and serve residents the portion size documented on the menu and acknowledged the portion size of the cake served was too small. The Dietary Manager stated she monitored trays, at random, for accuracy one time a week, and had last audited an evening shift meal two weeks</p>	F 363	<p>3. DSM/RD to re educate all dietary staff by 12/15/2012 regarding food likes/dislikes protocol, serving sizes and use of recipes to ensure all residents are served proper portion sizes and not served foods on their dislike list. ETD to re educate nursing staff to notify dietary if residents are served foods on their respective dislike list and if they think a portion size is too small for evaluation of portion size, by 12/15/2012.</p> <p>DSM to randomly monitor tray line 3 x weekly for 6 weeks beginning week of 12/15/2012 to ensure residents are not served foods on their dislike list and that portion size is correct.</p> <p>DSM to audit records to ensure all residents have a food likes/dislikes list on file to ensure that this is noted. This will be completed by 12/17/2012.</p> <p>4. Quality Assurance Team to meet at least weekly beginning week of 12/15/2012 to review audit findings and make recommendations' meeting to be held weekly until issues resolved.</p> <p>5. Date of Compliance 12/18/2012.</p>		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/13/2012
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
(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 363	Continued From page 9 prior to observation of the meal service on 11/13/12. According to the Dietary Manager, she had not identified any concerns related to portion size.  An interview with the Registered Dietitian (RD) on 11/13/12 at 7:30 PM, revealed staff was required to follow the menu and to serve the amount of food which was documented on the menu. The RD acknowledged staff had served the wrong portion size of spice cake during the evening meal on 11/13/12. The RD also confirmed Residents A, B, and C were not on calorie restricted or diabetic diets.	F 363			