

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

PRINTED: 08/07/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/24/2012 |
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| NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345 |
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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 A recertification survey was conducted on 07/22/12 through 07/24/12 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest S/S of an "E". | F 000 | | |
| F 371 SS=E | 483.35(l) 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, and review of the facility's policy and procedure, it was determined the facility failed to ensure food was stored and prepared under sanitary conditions. A review of the facility's Census and Condition, dated 07/22/12, revealed 36 out of 37 residents received their meals from the kitchen. Findings include: A review of the facility's "Food Safety Product Labeling and Dating Guide," dated 08/2009, revealed opened food should be covered and labeled when opened. A review of the "Safe | F 371 | F371 1) <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> A. The Dietary Manager supervised the removal of the build-up of black substance around and behind the blade of the can opener as identified. B. The Dietary Manager supervised the clean-up of the brown substance on the oven door as identified. C. The Dietary Manager supervised the placement of plastic cover over the meat slicer as identified. D. The Dietary Manager supervised complete disposal of all identified items in the freezer drawers that were open and not identified appropriately: onion rings, French fries, Talapia filets, catfish, fish sticks, chicken filets, and 12 country fried steaks. 2) <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> | |



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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bucky Juggins, NNA</i> | TITLE <i>Administrator</i> | (X6) DATE <i>8/13/12</i> |
|--|-------------------------------|-----------------------------|

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

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| F 371 | <p>Continued From page 1</p> <p>Operating Standards for Slicers, Choppers and Cutters," no date, revealed the meat slicer should be covered when not in use. A review of the "Master Cleaning Schedule," dated 08/2009, revealed the oven should be cleaned every Sunday and can openers cleaned every Saturday.</p> <p>Observations during the initial tour of the kitchen, on 07/22/12 (Sunday) at 9:35 AM, revealed:</p> <p>A. The can opener had a build-up of a black substance around and behind the blade.</p> <p>B. The oven had a build-up of a brown substance on the oven door.</p> <p>C. The meat slicer was stored with no cover.</p> <p>D. The freezer drawers had freezer bags of onion rings, french fries, Talapia filets, catfish, fish sticks, and chicken filets that were opened to air and were not labeled. Additionally, there were three stacks of approximately 12 country fried steaks in the drawer that were not in any kind of bag and were not labeled.</p> <p>An interview with the Dietary Manager, on 07/22/12 at 9:50 AM, revealed the can opener was suppose to be cleaned every day. She stated there was no way that much black build-up got that way in one day. She revealed the meat slicer should be covered when not in use. She stated the oven was suppose to be cleaned every week. She revealed the food in the freezer drawers should have been in sealed bags, labeled and dated when opened.</p> | F 371 | <p>The Dietary Manager, following the procedures in the Master Cleaning schedule, reviewed all items in the Dietary Department for cleanliness and proper storage. No further items were identified.</p> <p><u>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> The Dietary Manager educated all staff regarding: proper cleaning of equipment as identified per scheduled maintenance; proper storage of cleaned equipment not in use, and proper labeling and packaging of frozen foods in the freezer drawers (See attached sign-in sheet for documentation of this training – Attachment I).</p> <p><u>4) How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> The Dietary Manager developed tracking sheets to be used daily after cleaning of dietary equipment, proper covering of equipment that has been cleaned but not in use, and proper storage and labeling of food in the freezer drawers (See Attachments 2, 3, 4, and 5).</p> <p>5) All corrective action completed by</p> | 8/1/12 |

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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: 1967</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II (222)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/23/12. Muhlenberg Community Hospital was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> | K 000 |  | |

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

TITLE

(X6) DATE

Bobby Jaggars, NHA

Administrator

8/22/12

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| K 018 SS=F | <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty-five (45) beds with a</p> | K 018 | <p>K018</p> <p>1) <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> The Director of Plant Operations directed Engineering Staff to install spring loaded hinges on all 23 non-compliant bathroom doors addressed in the written statement of deficiencies.</p> <p>2) <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> A) The Director of Plant Operations examined all bathroom doors in each resident room on both floors of the Long Term Care Facility for compliance. B) No further doors were identified.</p> <p>3) <u>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> A) The Director of Plant Operations directed Engineering Staff to check all doors immediately following installation for proper closure.</p> | |

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| K 018 | <p>Continued From page 2</p> <p>census of thirty-seven (37) on the day of the survey. All facility corridor doors to resident rooms were blocked or had the potential to be blocked by the resident bathroom doors.</p> <p>The findings include:</p> <p>Observations, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, revealed the corridor doors to the resident rooms were blocked or had the potential to be blocked by the resident bathroom doors.</p> <p>Interviews, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, confirmed the observation of the doors not closing due to the bathroom doors blocking the doors.</p> <p>Observations were confirmed with the Administrator during the exit conference and she confirmed the bathroom doors were a problem but was unaware of a way to remedy the situation.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding</p> | K 018 | <p>B) The Administrator of Long Term Care and the Director of Plant Operations notified Long Term Care and Housekeeping Staff to monitor on-going compliance daily. (See Attachments 1 and 2).</p> <p>4) <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> A) The Director of Plant Operations conducts Hazard Surveillance Rounds semi-annually (January and July) and will check all door closures for continued safety. B) Records will be maintained in the Engineering Office.</p> <p>5) All corrective action completed by 8/10/12.</p> | 8/10/12 | |

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| K 018 | Continued From page 3 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches. | K 018 | | | |
| K 029 | NFPA 101 LIFE SAFETY CODE STANDARD | K 029 | | | |

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| K 029 SS=D | <p>Continued From page 4</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey. The facility failed to ensure 3 office doors were self closing.</p> <p>The findings include:</p> <p>Observations, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, revealed the door to the small office on the 2nd floor, the Director of Nursing office, and "Chris" office door did not have a door closer installed to keep the areas separate from the facility.</p> | K 029 | <p>K029</p> <p>1) <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> A) The Director of Plant Operations supervised the installation of automatic door closures on the Director of Nursing Office and "Chris's" office. B) The Administrator of Long Term Care directed the Long Term Care staff to remove the bulk of paper items from the small office on the second floor cited in the statement of deficiencies. C) The Director of Plant Operations supervised removal of the door from the hinges of the small office identified turning that space into a nook with no storage of paper items.</p> <p>2) <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> The Director of Plant Operations inspected all doors on both floors requiring automatic door closures and confirmed them to be working properly.</p> <p>3) <u>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> The Administrator of Long Term Care provided education to all Long Term Care staff via email regarding</p> | |

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| K 029 | Continued From page 5 Interview, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, revealed he was unaware the areas were considered hazardous storage thus requiring a door and a self closer. Observations were confirmed with the Administrator during the exit conference. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous | K 029 | appropriate use of automatic door closures (Attachment 3). 4) <u>How will facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> A) The Director of Plant Operations conducts hazard Surveillance Rounds semi-annually (January and July) and will check all door closures for continued safety. B) Records will be maintained in the Engineering Office. 5) All corrective action completed by 8/10/12. | 8/10/12 | |

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| K 029 | Continued From page 6 by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD | K 029 | | | |
| K 046 SS=F | Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on interview and facility record review, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey. The facility failed to ensure they conducted annual emergency lighting testing for the minimum requirement of Emergency lighting of at least 1-1/2 hour duration. The findings include: Observation and record review, on 07/23/12 at 3:15 PM with the Director of Plant Operations, revealed that the emergency lights, with battery backup, located throughout the facility had not been tested for 1-1/2 hours within the last year. | K 046 | K046 1) <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> The Director of Plant Operations instructed Engineering Staff to perform the annual 90-minute battery test on emergency battery lighting. 2) <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> The Director of Plant Operations directed Engineering Staff to replace all batteries in emergency lighting and testing was completed as required by the Life Safety Code. 3) <u>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> The Director of Plant Operations entered the Preventive Maintenance into the preventive maintenance program to | | |

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| K 046 | <p>Continued From page 7</p> <p>Interview, on 07/23/12 at 3:15 PM with the Director of Plant Operations, revealed he was aware the lighting had to be tested annually for 1-1/2 hours. He had a new assistant redo his logs and she must have misplaced the first 6 months of the year, which was when the test was completed. The facility was unable to provide documented evidence that this testing had been completed timely.</p> <p>Observations were confirmed with the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of | K 046 | <p>reflect the new annual testing date (Attachment 4).</p> <p>4) <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will supervise Engineering Staff to check battery light monthly per building maintenance program with documentation in the Engineering Office.</p> <p>5) Date of completion is 8/10/12.</p> | 8/10/12 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/23/2012 |
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| K 046 | <p>Continued From page 8</p> <p>combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of</p> | K 046 | | | |

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| NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL | | | STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345 | | |
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| K 046 | Continued From page 9 visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD | K 046 | | | |
| K 051 SS=F | A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 | K 051 | <p><u>1) How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> The Director of Plant Operations supervised the relocation of the remote fire annunciator panel located in the hospital Emergency Room entrance to the area directly in front of the registration clerk's desk.</p> <p><u>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> The Director of Plant Operations ensured that the above relocation provides unobstructed visual and audio monitoring to allow prompt response to any fire alarm.</p> | | |

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| K 051 | Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey. The facility failed to ensure the Alarm Control Panel was visible from the monitoring location. Additionally, the annunciator was difficult to hear over the air curtain and background noise. The findings include: Observation, on 07/23/12 at 3:00 PM with the Director of Plant Operations, revealed the Fire Alarm Control Panel (FACP) Annunciator was located at the entrance to the emergency room doorway. The panel is monitored by an office that is over 20 feet away and around a corner. The panel is not visible from the monitoring location. Further observation showed with the air curtain noise and the noise from the waiting room, it would be difficult to hear the annunciator. Interview, on 07/23/12 at 3:00 PM with the Director of Plant Operations, confirmed it would be difficult to hear or see the panel from the monitoring location. Observations were confirmed with the | K 051 | 3) <u>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will continue to assure through continual monitoring that the above measure will provide an unobstructed visual and audio monitoring capability and thus eliminate this deficient practice. 4) <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will instruct all registration clerks to continue monitoring this panel daily as defined in their individual job function. 5) Date of completion is 8/8/12. | 8/8/12 | |

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| K 051 | <p>Continued From page 11 Administrator during the exit conference</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>1-5.4.4 Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated.</p> <p>1-5.4.6 Trouble Signals. Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard.</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.</p> | K 051 | | | |

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| K 051 | Continued From page 12 5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally. 3-8.1* Fire Alarm Control Units. Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as standalone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance. | K 051 | | | |
| 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 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 | K 056 | K056 1) <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> The Director of Plant Operations established a service contract with Pennyrile Fire Safety to install proper sprinkler heads in all non-compliant compartments listed in the statement of deficiencies. (Attachment 5) | | |

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| K 056 | <p>Continued From page 13</p> <p>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 six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey. The facility failed to ensure all sprinkler heads in the same compartment would engage at the same heat level.</p> <p>The findings include:</p> <p>Observations, on 07/23/12 at 3:15 PM with the Director of Plant Operations, revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment, located in the 2nd floor shower room and room# 264, which would not allow both sprinkler heads to engage at the same heat level.</p> <p>Interview, on 07/23/12 at 3:15 PM with the Director of Plant Operations, revealed he was not aware that the sprinklers had to have the same engagement heat if the sprinkler heads are located in the same compartment.</p> <p>Observations were confirmed with the Administrator during the exit conference.</p> | K 056 | <p>2) <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> The Director of Plant Operations ordered Engineering Staff to inspect all rooms and any additional non-compliant sprinkler heads were identified and scheduled for replacement.</p> <p>3) <u>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will check all sprinkler heads for on-going compliance during Hazard Surveillance rounds conducted semi-annually (January and July).</p> <p>4) <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will review logs from rounds to assure compliance and thus the deficient practice will not recur.</p> <p>5) Date of completion is</p> | 8/31/12 | |

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| K 056 | Continued From page 14 Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same 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: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height 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. | K 056 | | | |
| K 062 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested | K 062 | K062 1) <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> | | |

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| K 062 | <p>Continued From page 15 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey. The facility failed to ensure sprinkler heads were maintained in reliable operating condition. The first floor had sprinkler heads with paint on the heads.</p> <p>The findings include:</p> <p>Observations, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, revealed the sprinkler heads throughout the first floor had paint on the heads.</p> <p>Interview, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, revealed he was aware the sprinkler heads could not have paint on them. The facility had painted recently and he had not checked the sprinkler heads for paint.</p> <p>Observations were confirmed with the Administrator during the exit conference.</p> <p>Reference: NFPA 25 (1998 Edition).</p> | K 062 | <p>The Director of Plant Operations established a service contract with Pennyrile Fire Safety to replace all sprinkler heads identified with paint on the heads in the statement of deficiencies. (Attachment 5)</p> <p>2) <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> The Director of Plant Operations ordered Engineering Staff to inspect all rooms and any additional sprinkler heads with paint were identified and scheduled for replacement.</p> <p>3) <u>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will check all sprinkler heads for on-going compliance during Hazard Surveillance rounds conducted semi-annually (January and July).</p> <p>4) <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will review logs from rounds to assure compliance and thus the deficient practice will not recur.</p> <p>5) Date of completion is</p> | 8/31/12 |

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| K 062 | Continued From page 16 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical 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. | K 062 | | | |
| K 064 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey. The findings include: Observation, on 07/23/12 at 2:45 PM with the Director of Plant Operations, revealed there was no signage stating that the hood suppression system must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system. | K 064 | <u>K064</u> 1) <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> The Director of Plant Operations established a service contract with Pennyrile Fire Safety to place correct signage in Dietary to state appropriate use of the hood suppression system prior to implementation of the class K fire extinguisher. (Attachment 6) 2) <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> The Director of Plant Operations assured that this is the only area affected in the building by this deficiency. 3) <u>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will check the security of the attached sign during hazard Surveillance rounds | | |

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| K 064 | Continued From page 17 Interview, on 07/23/12 at 2:45 PM with the Director of Plant Operations, revealed he was unaware of the signage requirement. Observation was confirmed with the Administrator during the exit conference Reference: NFPA 10 (1998 Edillon). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. | K 064 | conducted semi-annually (January and July). 4) <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will check the security of the attached sign during Hazard Surveillance Rounds conducted semi-annually (January and July). 5) Date of completion is _____ | 8/31/12 |
| K 076 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 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 | K 076 | 1) <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> A) The Director of Plant Operations placed two (2) signs on the wall in the oxygen storage room/activities closet to indicate an area designated for full oxygen tanks and a separate area designated for empty oxygen tanks – “Full – Ready to Use / Empty Cylinder – Do Not Use”. B) The Director of Plant Operations secured the helium tank located in the Activities storage closet by chaining it to both sides of stable shelving in the closet to prevent tipping over. | |

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OMB NO. 0938-0391

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|---|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL | | | STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345 | | |
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| K 076 | <p>Continued From page 18 standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey. The facility failed to have appropriate signage for the oxygen storage closets and failed to ensure the helium tank was stored securely.</p> <p>The findings include:</p> <p>Observation, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, revealed there was no signage indicating full or empty oxygen tanks in the oxygen storage room/activities closet.</p> <p>Interview, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, revealed he was not aware the oxygen tanks needed signage for the door containing the oxygen storage and a sign indicating full or empty.</p> <p>Observation, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, revealed the helium tank located in the Activities Office was not secured properly to prevent the tank from falling over. A bracket was under the tank that was supposed to prevent tipping but the bracket was not anchored to the floor.</p> <p>Interview, on 07/23/12 between 1:30 PM and 3:10 PM with the Director of Plant Operations, revealed he was unaware the helium tank was not secure.</p> <p>Observations were confirmed with the</p> | K 076 | <p>C) The Director of Plant Operations placed appropriate signage on exterior side of the door of the oxygen storage room/activities closet – "DANGER – Gas Cylinder Storage Area".</p> <p>2) <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> The Director of Plant Operations searched the entire Long Term Care area (both floors) to identify any additional oxygen tank storage. None was found.</p> <p>3) <u>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will ensure that all signs will remain in place through Engineering rounding throughout the facility.</p> <p>4) <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will check the security of the signage during Hazard Surveillance Rounds conducted semi-annually (January and July).</p> <p>5) Date of completion – 8/10/12</p> | 8/10/12 | |

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| NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL | | | STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42346 | | |
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| K 076 | <p>Continued From page 19 Administrator during the exit conference.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p> <p>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</p> | K 076 | | | |

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| K 076 | Continued From page 20 Reference: NFPA 99 (1999 edition) Section 4-3.1.1.2 Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. Section 4-3.1.1.8 Cylinders in storage shall be secured and located to prevent them from falling or being knocked over. 4-3.5.2.2 Storage of Cylinders and Containers-Level 1. 29.* Cylinders shall not be supported by, and neither cylinders nor containers shall be placed in proximity of, radiators, steam pipes, or heat ducts, and other trained personnel, shall provide and enforce regulations. Very cold cylinders or containers shall be handled with care to avoid injury, of oxygen and nitrous oxide in storage rooms of approved construction, and for the safe handling of these agents in 31. Cylinders and containers shall not be handled in anesthetizing locations. Storage locations for flammable inhalants, gloves, or other materials contaminated with oil or grease, shall be limited by space allocation and regulation (c) Making Cylinder and Container Connections. In storage locations, cylinders shall be properly secured | K 076 | | |

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| K 076 | Continued From page 21 1.* Wrenches used to connect respiratory therapy equipment in racks or adequately fastened. No cylinders containing oxyshall be manufactured of steel or other suitable material gen or nitrous oxide, other than those connected to anesthetic of adequate strength. apparatus, shall be kept or stored in anesthelizing locations. 2. Cylinder valves shall be opened and connected in accor- (b) Nonflammable Gases. dance with the following procedure: 1. Storage shall be planned so that cylinders can be used in a. Make certain that apparatus and cylinder valve connec- the order in which they are received from the supplier. tions and cylinder wrenches are free of foreign mate- 2. If stored within the same enclosure, empty cylinders shall rials. be segregated from full cylinders. Empty cylinders shall be b. Turn the cylinder valve outlet away from personnel. marked to avoid confusion and delay if a full cylinder is Stand to the side-not in front and not in back. Before needed hurriedly. connecting the apparatus to cylinder valve, momen- 3. Cylinders stored in the open shall be protected against larly open cylinder valve to eliminate dust. extremes of weather and from the ground beneath to prec. Make connection of apparatus to cylinder valve. vent rusting. During winter, cylinders stored in the open Tighten connection nut securely with an appropriate shall be protected against accumulations of ice or snow. wrench [see 4-3.5.2.1(c)1]. In summer, cylinders stored in the open shall be screened | K 076 | | | |

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| K 076 | Continued From page 22 d. Release the low-pressure adjustment screw of the regu- against continuous exposure to direct rays of the sun in lator completely. those localities where extreme temperatures prevail. | K 076 | | | |
| K 154 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on interview and facility policy and procedure review, the facility failed to develop a fire watch policy in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey. The findings include: Policy and Procedure review, on 07/23/12 at 3:15 PM with the Director of Plant Operations, revealed the facility had no written fire watch policy. Interview, on 07/23/12 at 3:15 PM with the | K 154 | <u>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> The Director of Plant Operations wrote a new policy and procedure to address all guidelines to follow for a "Fire Watch." (LS Amended Attachment 1) The Director of Plant Operations included in this policy specific guidelines for notification once a fire watch has been implemented. (Refer to Section A of the policy designated in Attachment 1) The Director of Plant Operations forwarded this plan to all members of the Hospital Safety Committee for approval and recommendations. (LS Amended Attachment 2 - Note: The Administrator of LTC is a member of this committee) <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> | | |

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| K 154 | Continued From page 23 Director of Plant Operations, revealed he was aware there needed to be a policy, if the sprinkler system or fire alarm system would be non-functioning for 4 or more hours in a 24 hour period. He was unaware they did not have an actual copy of their procedure. Observations were confirmed with the Administrator during the exit conference. Reference; NFPA 101 (2000 edition) 9.7.6* Sprinkler System Shutdown. 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. | K 154 | The Director of PLant Operations is responsible to assure compliance of this policy for all areas of the hospital including all areas of the LTC Facility. Therefore this policy has the potential to affect all residents of LTC. <u>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> The Director of Plant Operations will review this plan annually and present it to the Hospital Wide Safety Committee for final approval. <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> The Director of PLant Operations will maintain all documentation indicating when a "Fire Watch" has been performed in the Engineering Office on the designated form. (LS Amended Attachment 3) <u>Date of Completion</u> | 8/20/12 | |