

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

RECEIVED  
JUN 8 2012  
05/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185262</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MADISON HEALTH AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>131 MEADOW LARK DRIVE RICHMOND, KY 40461</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	--	----------------------

F 000	INITIAL COMMENTS	F 000		
F 253 SS=E	<p>A standard health survey was conducted on 05/08-10/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure housekeeping and maintenance was provided to maintain a sanitary, orderly, and comfortable interior. One kitchen door was observed to be rusted at the bottom with metal missing, the tile in the floor in front of the kitchen door was observed to have cracked/missing tiles, two resident rooms (rooms 8 and 25) were observed to have holes in the walls, three resident rooms (rooms 3, 7, and 25) were observed to have scuffed walls, and the vinyl fabric on the arms of one geri-chair was observed to be rough and cracked.</p> <p>The findings include: A review of the facility's policy titled, "Preventive Maintenance Program," dated 11/01/97, revealed any staff person identifying a maintenance issue was required to complete a detailed work order and sign it.</p>	F 253	<p>F253</p> <p>1. All identified maintenance issues will be corrected by 6/13/2012 by the Maintenance Director. This includes the rusted kitchen door, the tile in front of the kitchen door that are cracked and missing, holes in wall in rooms #8 and #25, scuffed areas on walls in room #3, #7 and #25 and vinyl fabric on the arms of one Geri chair in room #39. No specific residents were identified.</p> <p>2. Administrator to complete a one time audit of every room in center, including the kitchen by 6/14/2012 to identify any cracked tiles, missing tiles, rusted doors and/or holes in the walls or scuffed. Any issue identified will have a work order completed and fixed per policy no later than 6/13/2012, unless ordering is required and then it will be fixed upon piece/part arrives.</p> <p>3. Administrator and Maintenance Director to complete a weekly walk through/audit 4 weeks of all rooms and kitchen area to ensure any cracks in tiles, missing tiles, holes or scuffs in wall and /or rust on doors beginning 6/14/2012. Education Training Director to re educate staff by 6/13/2012 regarding how to complete a work order, when to complete a work order and to report any maintenance /housekeeping issues to the Administrator/DON/Maintenance Director per work order policy.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roy T. Baber TITLE: Administrator (X6) DATE: 6/2/12

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.

Received Time Jun. 8. 2012 1:20PM No. 8277

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

PRINTED: 05/24/2012  
FORM APPROVAL  
OMB NO. 0938-039

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  05/10/2012
--	--	--	--

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

F 253	<p>Continued From page 1</p> <p>During the environmental tour of the facility on 5/10/12, at 2:00 PM, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> <li>-The back door in the kitchen leading to the outside was observed to be rusted at the bottom with pieces of metal missing. The floor tiles in front of the door were observed to be cracked with pieces of tile missing.</li> <li>-The walls in resident rooms 3 and 7 were observed to be scuffed and the sections of the finish to the wall on the left side of the windows in both rooms were observed to be chipped.</li> <li>-Resident room 8 was observed to have a hole in the wall on the right side of the window.</li> <li>-Resident room 25 was observed to have a hole in the wall and scuff marks were observed on the wall next to the door.</li> <li>-The vinyl fabric on the arms of a geri-chair in resident room 39 was rough and cracked.</li> </ul> <p>An Interview with the Administrator on 05/10/12, at 2:55 PM, revealed the Maintenance Supervisor (MS) was on vacation for the week and was unable to be reached. The Administrator stated the facility utilizes a work order system to identify and request needed repairs throughout the facility. The Administrator stated the staff member that identified an area in need of repair was to complete a maintenance work order which was kept at each nursing station. According to the Administrator, the staff person was then required to place the completed work order in the</p>	F 253	<p>4. QA team (consisting of at least Medical Director, Administrator, Director of Nursing, ADON, UM, Social Services Director and Life Enrichment Director) to review all audit findings and make revisions to plan as needed every week x2 weeks beginning 6/13/2012, then at least monthly or until issue resolved.</p> <p>5. Date of Compliance 6/14/2012</p>	
-------	---	-------	---	--

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/10/2012
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40476		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	Continued From page 2 Maintenance Supervisor's mailbox, and the Maintenance Supervisor was to check his mailbox every day. The Administrator also stated when the issue was resolved the Maintenance Supervisor was to place the form in the Administrator's mailbox for review. The Administrator stated he makes environmental rounds daily and these areas had not been identified.	F 253			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure care was provided in accordance with physician's orders for one of eighteen sampled residents (Resident #5). Resident #5 had a physician's order for oxygen to be administered at two liters per minute by nasal cannula. However, observation on 05/09/12 and 05/10/12, revealed the oxygen was provided to Resident #5 at three liters a minute.  The findings include:  A review of the facility's policy entitled, "Physician's Orders," with a revision date of July 2008, revealed all clinicians may take verbal, telephone, and electronic orders as permitted by their state Licensure Board. In addition, a review of the policy revealed the physician's original order was to be discontinued when the	F 281	P281  1. Resident #5 physician and family was made aware that order for oxygen was written for 2 l/m via nasal cannula and had been increased to 3 l/m by hospice per verbal order but no written order had been completed. No new orders were obtained and order clarified and written in the clinical record for 3 l/m oxygen via nasal cannula by the Unit Manager(UM) on 5/10/2012. Resident #5 has experienced no change. Medical Director made aware of Resident #5 verbal and written order not being consistent by the UM on 5/10/2012.  2. Director of Nursing (DON), UM and/or Assistant Director of Nursing (ADON) to audit all written physicians orders one time in the record to identify if any order does not correspond /match what is on the Medication Administration Record(MAR) by 6/12/2012. Any issue identified will be immediately addressed and orders clarified per physician order. All oxygen orders will be verified by the UM/ADON x30d beginning 5/27/2012 to identify any inconsistency in order compared to the MAR. Any discrepancy will be immediately reported to the physician for clarification.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 05/24/2012  
FORM APPROVED  
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  05/10/2012
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 281	<p>Continued From page 3 physician's order was changed.</p> <p>A review of the medical record for Resident #5 revealed the facility had admitted the resident on 04/19/11, with diagnoses which include Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, and Renal Failure.</p> <p>A review of a quarterly Minimum Data Set (MDS) assessment for Resident #5 dated 02/20/12, revealed the facility had assessed the resident to have moderately impaired cognition.</p> <p>A review of the physician's orders for Resident #5 revealed an order dated 04/01/12, for oxygen to be administered at 2 liters per minute by nasal cannula. The resident also had a physician's order dated 04/01/12 for hospice services.</p> <p>Observation of Resident #5 on 05/09/12, at 8:55 AM, 10:05 AM, 12:35 PM, 2:10 PM, 3:30 PM, and 4:30 PM, and on 05/10/12, at 8:15 AM, revealed oxygen was delivered to the resident at 3 liters by nasal cannula.</p> <p>An interview with the Unit Manager (UM) of the A and B Wings on 05/10/12, at 10:00 AM, revealed she had set the resident's oxygen to be administered at 3 liters per minute by nasal cannula on 05/09/12 and 05/10/12. The UM stated the resident's hospice nurse had been at the facility on 05/09/12, and had requested the UM to increase the resident's oxygen to 3 liters per minute by nasal cannula. The UM stated she thought the hospice nurse had obtained a physician's order for the change in the oxygen and acknowledged she should have confirmed</p>	F 281	<p>3. Education Training Director to re educate all Licensed Personnel regarding policy for obtaining verbal orders and transcribing in writing to the MAR by 6/12/2012. DON/ADON/UM to audit 10 records weekly x 3 weeks beginning week of 6/12/2012 to ensure all orders match what is on MAR. RDCO to audit 5 records monthly x 3 months beginning week of 6/12/2012 to ensure all orders transcribed to MAR per written order, any discrepancy will be reported to the physician for clarification. UM/ADON to audit all residents receiving oxygen 3 x weekly x 4 weeks beginning 6/13/2012 to ensure resident is receiving oxygen per the written physician order and the MAR reflects the written order.</p> <p>4. QA team (consisting of at least Medical Director, Administrator, Director of Nursing, ADON, UM, Social Services Director and Life Enrichment Director) to review all audit findings and make revisions to plan as needed every week x2 weeks beginning 6/13/2012, then at least monthly or until issue resolved.</p> <p>5. Date of Compliance 6/14/2012</p>		

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

PRINTED: 05/24/2012  
FORM APPROVED  
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  05/10/2012
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 281	Continued From page 4 the order with the physician. In addition, the UM also acknowledged she had written the change in the resident's oxygen administration on the treatment sheet without first confirming the order with the physician.  An interview with the hospice nurse for Resident #5 was conducted on 05/10/12, at 10:05 AM, and the hospice nurse acknowledged he had asked the UM to increase the resident's oxygen to 3 liters per minute by nasal canula. According to Resident #3's hospice nurse, he thought the UM wrote the physician's order for the change in the oxygen.  An interview conducted with the DON on 05/10/12, at 10:10 AM, revealed the facility nurse was responsible for ensuring the physician's order had been obtained/written for the change in the resident's oxygen administration.	F 281			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F431  1.No specific resident was identified.  2.Director of Nursing(DON) to complete a one time audit of all medication rooms, all medication/treatment carts and all medication refrigerators to identify any medication opened and not dated per policy, not stored per policy and /or labeled per policy, that medication carts are locked, clean and that all narcotics are locked and accounted for by 06/14/2012. Any medication opened and not dated will be discarded, reordered and dated by the UM upon arrival from pharmacy. Any medication that is not stored per policy will be discarded per policy and replaced by the center immediately		

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

PRINTED: 05/24/2012  
FORM APPROVED  
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  05/10/2012
--	--	--	--

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 431	<p>Continued From page 5</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure all drugs and biologicals were labeled and dated in accordance with currently accepted professional principles. One multi-use vial of Lidocaine HCL 1% (local anesthetic) was observed to be opened and available for use; however, the vial did not contain a label with the name of the resident whom it was intended for nor did the vial contain the date the vial was opened.</p> <p>The findings include:</p> <p>An interview was conducted with the DON on 05/10/12, at 2:30 PM, and revealed the facility did not have a policy related to dating and labeling</p>	F 431	<p>3. Education Training Director (ETD) to re educate licensed personnel regarding p/p for storage of biological, dating of opened liquids/medications and following manufactures recommendation for all opened medications by 06/12/2012.</p> <p>ETD to re educate licensed personnel regarding policy that all medications are stored per policy, that all treatments carts are clean and all narcotics are locked by 6/12/2012.</p> <p>Regional Director of Clinical Services to re educate DON and UM regarding p/p for storage of medications, dating opened medications, narcotic storage policy, medication cleanliness policy and following manufactures recommendation for all opened medications by 6/10/2012..</p> <p>Pharmacy representative to audit at least all three(3) medication rooms and medication refrigerators for expired or undated opened medications monthly x 2 months beginning 6 th month visit.</p> <p>DON to audit all medication refrigerators 2 x week x 4 weeks to ensure all medications are dated if opened, stored per policy that medication carts are cleaned, locked and all medications are , that medication cart is clean and medications stored and discarded per manufactures recommendation beginning week of 6/12/2012.</p> <p>UM to audit medication and treatment carts to ensure opened liquids are dated and discarded per manufactures recommendation 1 x week x 4 weeks beginning week of 6/12/2012.</p>	
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 05/24/2012  
FORM APPROVED  
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  05/10/2012
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 431	<p>Continued From page 6</p> <p>medications. However, the interview with the DON revealed nurses were expected to date and initial all multi-use vials of medication at the time the medication was opened. The DON also stated nurses were to ensure the vials were labeled with the name of the resident for whom the medication was intended or to place the medication in a bag which contained the prescription label.</p> <p>Observation of the medication cart for the E Wing of the facility on 05/10/12, at 2:15 PM, revealed a vial of Lidocaine HCL 1% was observed in a drawer in the medication cart opened and available for use. The vial did not contain a label indicating whom the medication was intended for nor did the vial contain a label indicating the date the vial had been opened.</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on 05/10/12, at 2:20 PM, revealed the LPN stated she was unaware the vial had been opened and not labeled with the resident's name for whom it was intended for and did not contain the date it had been opened. The LPN stated she was required by the facility to discard any open and unlabeled or undated medications. The LPN revealed multi-use vials of medication were required by the facility to be labeled and dated when opened.</p> <p>An interview with the Unit Manager (UM) for the E Wing on 05/10/12, at 2:25 PM, revealed the UM stated nurses were required to date and initial any multi-use vials of medication as soon as they were opened. The UM also revealed the nurses were responsible to ensure labels containing the resident's name were on the vial or the</p>	F 431	<p>4. QA team to review monthly X 3 to ensure compliance and make adjustments where needed.</p> <p>5. Date of compliance 6/14/2012.</p>	

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/10/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40476
--	---

(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 431	Continued From page 7 medication was placed in a bag with the prescription label on it. The UM stated she conducts an audit on the medication cart at least once a week and had done one on 05/07/12 or on 05/08/12. The UM stated she did not document her audits; however, she reported any issues she identified to the Director of Nursing (DON). The UM revealed she had not identified any issues with not labeling or dating multi-use vials of medication.  An interview conducted with the DON on 05/10/12, at 2:30 PM, revealed the UM audited the medication carts at least once a week and had not identified any issues with unlabeled and undated medications being in the medication carts. The DON also revealed the UM did not document the audits.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection	F 441	F441 1. Resident #7 physician and family was notified on 5/10/2012 that staff had entered the room without protective equipment per policy. No new orders were received. The Medical Director was notified that the staff entered the resident room without protective equipment per infection control policy on 5/10/2012.  2. DON/UM to audit all records to identify any resident with isolation orders by 6/12/2012. All residents with isolation orders will be monitored at least 2 x daily 2 weeks beginning 6/12/2012 to ensure that infection control practices were observed per physicians order and EHSI policy.	

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/10/2012
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 441	<p>Continued From page 8</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, the facility failed to ensure staff utilized appropriate infection control practices for one of twenty sampled residents (Resident #7). A review of documentation in Resident #7's medical record revealed staff was to use contact precautions when caring for Resident #7, however, observation revealed staff failed to use personal protective equipment as indicated for contact precautions.</p> <p>The findings include:  A review of the facility's infection control policy (revised November 2009) revealed the facility</p>	F 441	<p>3. ETD to re educate all nursing staff by 6/12/2012 regarding the infection control policy and procedure. This includes isolation policy and procedure, hand washing policy and personal protective equipment recommendation. RDCO(Regional Director of Clinical Operations) to audit any resident with isolation orders and ensure that the infection control policy is followed by auditing the staff providing care to ensure that all protective equipment is worn and available. RDCO completed an audit of availability of personal protective equipment. All personal protective equipment was available. RDCO to audit to ensure that all personal protective equipment is available for use at least monthly.</p> <p>4. QA team to review monthly X 3 to ensure compliance and make adjustments where needed.</p> <p>5. Date of compliance 6/14/2012.</p>		

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

PRINTED: 05/24/2012  
FORM APPROVED  
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  05/10/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40476
--	---

(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 441	<p>Continued From page 9</p> <p>staff used Standard Precautions for all residents when providing care. In addition to Standard Precautions, transmission based precautions including contact, droplet, and airborne precautions were to be used as indicated. According to the policy/procedure, Contact Precautions included "wearing gloves when entering the resident's room, ensure hands do not touch potentially contaminated environmental surfaces or items in the room after glove removal, wear a gown when entering the room, remove the gown before leaving the resident's environment, and ensure clothing does not contact potentially contaminated environmental surfaces after gown removal."</p> <p>A review of the medical record for Resident #7 revealed the resident was admitted to the facility on 07/25/11, with diagnoses that included Diabetes, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Degenerative Joint Disease. A review of Resident #7's nurse's notes revealed Contact Precautions had been initiated on 05/01/12, related to Resident #7's blood culture results.</p> <p>Observations on 5/08/12, 05/09/12, and 05/10/12, revealed a cart outside the room of Resident #7 that contained gowns, gloves, and masks. However, observations revealed staff did not use gowns when they entered Resident #7's room or when providing personal care for Resident #7. On 05/08/12, at 4:10 PM, staff was observed in Resident #7's room reapplying the resident's oxygen cannula. Although staff was observed to be wearing gloves while providing care to the resident, they failed to wear a gown in</p>	F 441		
-------	---	-------	--	--

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

PRINTED: 05/24/2012  
FORM APPROVED  
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  05/10/2012
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40476	
(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 441	<p>Continued From page 10</p> <p>accordance with facility policy when providing the resident's care. On 5/08/12, at 5:00 PM, Resident #7 was observed to use the call light to summon staff to his/her room to assist the resident onto a bedpan. A State Registered Nurse Aide (SRNA) and a Licensed Practical Nurse (LPN) responded to Resident #7's call light and donned gloves to assist the resident; however, neither staff member wore a gown while assisting the resident. In addition, observations of a head-to-toe skin assessment by an LPN and a SRNA on 05/09/12, at 11:15 AM, revealed both staff members wore gloves, but neither staff member wore a gown.</p> <p>An interview conducted with SRNA #1 on 05/08/12, at 4:15 PM, revealed the sign on the door was to let staff know to use gloves when delivering care. The SRNA acknowledged there was a cart in the hall with gowns/masks available, but staff only used gloves to provide care to Resident #7.</p> <p>An interview with LPN #2 on 05/10/12, at 8:55 AM, revealed staff was to wear gowns and gloves when providing care for Resident #7. According to LPN #2, the nurses were responsible to ensure care was provided as ordered.</p> <p>An interview with the Staff Development Coordinator (SDC) at 3:05 PM on 05/10/12, revealed the SDC had not specifically educated the staff regarding Contact Precautions, but had in-serviced staff regarding handwashing related to infection control.</p> <p>An interview with the Director of Nursing (DON) on 05/10/12, at 10:45 AM, revealed the Unit</p>	F 441		

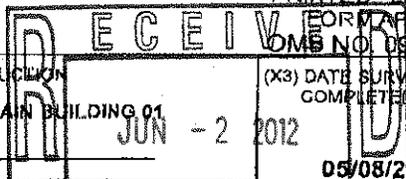
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2012  
FORM APPROVED  
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  05/10/2012
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)	(X6) COMPLETION DATE	
F 441	Continued From page 11 Managers and LPNs should ensure staff utilized Contact Precautions when providing care to Resident #7. The DON further stated, "I was over there but didn't notice the staff was not using appropriate precautions."	F 441			

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

PRINTED: 06/24/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185282	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/08/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475 Division of Health Care Southern Enforcement Branch
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 1989  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type V (000)  SMOKE COMPARTMENTS: Seven  FIRE ALARM: Complete automatic fire alarm system.  SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.  GENERATOR: Type II diesel generator.  A life safety code survey was initiated and concluded on 05/08/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1½ hour duration is	K 046		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Roger Baker, Administrator* TITLE: *Administrator* (X6) DATE: *5/2/12*

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.

Received Time Jun. 2. 2012 10:34AM No. 8113

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/08/2012
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
K 046	Continued From page 1 provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain emergency lighting at an exit according to NFPA standards. This deficient practice affected one of seven smoke compartments and staff. No residents were directly affected by this practice. The facility has the capacity for 92 beds with a census of 87 on the day of the survey.  The findings include:  During the Life Safety Code tour on 05/08/12, at 02:00 PM, with the Director of Maintenance (DOM) an exterior exit located in the dining room of the facility was observed not to have emergency lighting to the public way as required. An interview with the DOM on 05/08/12, at 02:00 PM, revealed the DOM was not aware the exit needed emergency lighting.  Reference: NFPA 101 (2000 Edition).  7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks	K 046	K 046 1. No resident was identified as being affected.  2. The identified exit located in the dining room will be maintained such that it meets the required standards.  3.No other exit was identified as having not met the standards however any exits with required emergency lighting will be tested for functionality.  The Maintenance Director will test all emergency lighting at required intervals and report to the Administrator relative to compliance and/or needed repairs.  4. Compliance will be reported to the QA committee annually.  5. Completion date 6/14/2012.	

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/08/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40476
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 046	<p>Continued From page 2</p> <p>(5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.</p> <p>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>7.9.2.4* Battery-operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electrical Code.</p>	K 046		
-------	--	-------	--	--

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/08/2012
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
K 046	Continued From page 3 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 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain the fire alarm system by NFPA standards. This deficient practice affected seven of seven smoke compartments, staff, and all the residents. The facility has the capacity for 92 beds with a census of 87 on the day of the survey.	K 054		

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/08/2012
--	--	--	--

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

K 084	<p>Continued From page 4</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 05/08/12, at 3:00 PM, with the Director of Maintenance (DOM), a record review revealed the last sensitivity testing of the smoke/heat detectors was completed on 03/20/10. This type of testing is due every two years. An interview on 05/08/12, at 3:00 PM, with the DOM revealed he was not aware the smoke/heat detectors needed testing.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>7-3.2.1*</p> <p>Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer's calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement</li> </ol>	K 054	<p>K054</p> <ol style="list-style-type: none"> <li>1. No resident was identified as having been negatively affected.</li> <li>2. All smoke/heat detectors will have been maintained as required by the Director of Maintenance or by a qualified NFPA smoke/heat detector contractor.</li> <li>3. Records of such testing will be maintained to indicate smoke/heat detectors are functioning properly and needed repair, adjustments will be completed.</li> <li>4. The QA committee will review Annually to ensure compliance.</li> <li>5. Date of completion 6/14/2012.</li> </ol>	
-------	---	-------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/08/2012
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	
K 054	Continued From page 5 whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.  7-3.2.2 Test frequency of interfaced equipment shall be the same as specified by the applicable NFPA standards for the equipment being supervised.  7-3.2.3 For restorable fixed-temperature, spot-type heat detectors, two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year, with records kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested.	K 054			
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Transferring of oxygen is:	K 143			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/08/2012
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
K 143	<p>Continued From page 6</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a liquid oxygen storage room according to NFPA standards. This deficient practice affected one of seven smoke compartments, staff, and approximately twenty residents. The facility has the capacity for 92 beds with a census of 87 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 05/08/12, at 02:05 PM, with the Director of Maintenance, (DOM) a corridor door to the liquid oxygen storage room was observed not to have a 45-minute fire protection rating as required. The</p>	K 143		

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/08/2012
--	--	--	--

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

K 143	<p>Continued From page 7</p> <p>oxygen storage room did not have the appropriate signage as well. An interview with the DOM on 05/08/12, at 02:05 PM, revealed the DOM was not aware of liquid oxygen storage requirements.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</p> <p>c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</p> <p>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.</p> <p>The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.2.3.2.3.1</p>	K 143	<p>K 143</p> <ol style="list-style-type: none"> <li>1. This practice was identified to potentially affect approximately twenty unidentified residents</li> <li>2. No other oxygen storage area exist in the facility.</li> <li>3. The corridor door to the oxygen storage room will meet the 45 minute fire protection rating as required. Signage to include "Transferring is Occurring" and that "Smoking in the Immediate Area is Prohibited" will be in place.</li> <li>4. The Maintenance Director will audit annually to ensure the door is functioning properly and the signage is in place and report to the QA committee quarterly.</li> <li>5. Date of compliance 6/14/2012.</li> </ol>	
-------	--	-------	---	--

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/08/2012
--	--	--	--

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

K 143	Continued From page 8 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows: (1) 2-hour fire barrier - 1 1/2-hour fire protection rating (2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42.	K 143		
-------	--	-------	--	--