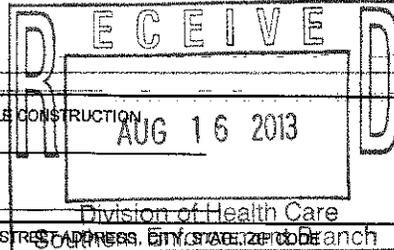


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 08/08/2013
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 07/25/2013 |
|--|--|--|--|

| | |
|--|---|
| 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 000 | INITIAL COMMENTS A standard health survey was conducted on 07/23-25/13. Deficient practice was identified with the highest scope and severity at "E" level. | F 000 | F 253 1. No resident was specifically identified. All residents have the potential to be affected. | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable interior. Observation during the environmental tour on 07/25/13, beginning at 3:15 PM, revealed a stained privacy curtain in a resident room, raised flooring with a chipped edge in the main lobby, and a missing piece of fascia board at the back exterior of the building. The findings include: A review of the facility's policy titled, "Maintenance Request Policy," undated, revealed any staff person could submit a maintenance/housekeeping request when finding an issue to be repaired or cleaned. The policy revealed maintenance issues would also be discussed at the daily morning Department Manager's meeting. The Maintenance Director was required to discuss any maintenance issues with the Administrator regarding the progress, | F 253 | 2. The privacy curtain identified in room 23-A was replaced with a clean curtain. An audit of all privacy curtains to determine cleanliness was performed with any soiled ones removed and replaced on 8/25/2013. The raised and chipped flooring in the front foyer was secured and made safe on 8/25/13. An audit of other flooring areas was conducted with no concerns noted 8/25/13. The missing fascia board at the rear of the building was repaired. An audit of the exterior of the building on 8/25/13 did not reveal other areas needing repair. 3. The Administrator and House Keeping Supervisor will conduct weekly monitoring to determine compliance of privacy curtain QA process beginning 8/19/2013. The Administrator and Maintenance Director will conduct weekly monitoring audits to determine compliance of flooring issues and exterior maintenance needs beginning 8/19/2013. 4. The QA committee (to include the Maintenance and House Keeping Directors, DON, ADM, SSD, Medical Director, ADON, DM) will review all audit findings and make revisions where needed to ensure compliance each week for 2 weeks beginning 8/19/2013 and then monthly as needed or until resolved. | |

| | | |
|--|------------------------|----------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Roy Barber</i> | TITLE Administrator | (X6) DATE 8/16/13 |
|--|------------------------|----------------------|

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

| | | | |
|--|--|--|--|
| 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 07/25/2013 |
|--|--|--|--|

| | |
|--|---|
| 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 253 | <p>Continued From page 1</p> <p>obstacles encountered, and the expected date of completion.</p> <p>Observation during the environmental tour on 07/25/13, beginning at 3:15 PM, revealed:</p> <ul style="list-style-type: none"> -Resident room 23-A was observed to have a privacy curtain with a brown stain along the bottom of the curtain. -The flooring in front of the desk in the main lobby was observed to be raised with a chipped edge. -A piece of fascia board was missing at the back exterior of the building potentially allowing entrance for pests. <p>An interview conducted with the Housekeeping Director on 07/25/13, at 5:00 PM, revealed housekeeping staff was required to check all resident rooms daily for areas in need of cleaning. The Housekeeping Director stated staff that identified housekeeping issues was required to fill out a Communication Form request, and place it in his mailbox which he checked several times daily. The Housekeeping Director stated he monitored three random resident rooms daily as part of the Quality Assurance program to ensure all housekeeping issues were being identified. According to the Housekeeping Director, the privacy curtain in resident room 23-A had not been identified as being in need of cleaning.</p> <p>An interview conducted with the Maintenance Director on 07/25/13, at 5:10 PM, revealed employees were required to fill out a Communication Form request for identified areas in need of repair and place it in his mailbox. The</p> | F 253 | 5. Date of Compliance: 8/25/13 | |
|-------|--|-------|--------------------------------|--|

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0394

| 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 07/25/2013 |
|---|---|---|--|----------------------|---|
| 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 253 | Continued From page 2 Maintenance Director stated he checked his mailbox several times daily for the requests. The Maintenance Director stated he did a weekly round to identify environmental concerns, but he had not observed the identified areas in need of repair. An interview conducted with the Administrator on 07/25/13, at 5:15 PM, revealed staff that identified maintenance or housekeeping issues was required to fill out a Communication Form request and place the form in the Maintenance Director's or the Housekeeping Director's mailbox. The Administrator stated he had not been made aware of the identified areas in need of repair or cleaning. | F 253 | | | |
| 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 (1) When the Infection Control Program determines that a resident needs isolation to | F 441 | F 441 1 Resident # 11 family and physician were notified that the nurse performing the glucose monitoring did not follow completely the infection control protocol for such monitoring. The Medical Director was notified the nurse did not follow the infection control policy relative to glucose monitoring. 2. The ETD monitored 5 glucose checks by 8/20/13 to identify any issue with glucometer cleaning or any issues with infection control. Any issues identified were immediately reported to the MD and staff was retrained by the ETD. ETD, DON and ADON monitored staff providing care to 10 residents by 8/20/13 to identify issues with hand washing, use of gloves for any infection control issues. No issues were identified. ADON reviewed cultures for last 30 days to identify any resident who would require contact precautions per CDC guidelines. No issues identified. DON reviewed all infections for past 60 days to identify and track any issues by 8/20/13. No issues were identified. | | |

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

PRINTED: 08/08/2013
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 07/25/2013 |
| 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 3</p> <p>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 facility policy review it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for one of eighteen sampled residents (Resident #11). Observation during medication administration on 07/23/13, revealed staff failed to wash/sanitize their hands after cleaning a glucose monitoring device and checking Resident #11's blood glucose.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Glucometer Cleaning Checkoff", undated, revealed staff was required prior to obtaining a specimen for blood glucose monitoring to obtain three paper towels,</p> | F 441 | <p>3. The Education and Training Director completed infection control re-education for all nursing staff by 8/21/13 which included hand washing, glucometer cleaning and CDC guidelines to ensure infection control is followed.</p> <p>ADON to review all cultures X 30 days beginning 8/22/13 to ensure all infections are reviewed and resident is placed in isolation.</p> <p>ETD/UM to monitor 2 licensed nurses completing glucometer monitoring to ensure all infection control procedures are followed weekly X 4 weeks beginning week of 8/22/13, to be completed by 8/21/13.</p> <p>DON, ADON and ETD to monitor 5 staff weekly X 4 weeks beginning the week of 8/22/13 to ensure hand washing is completed correctly.</p> <p>DON to review all infections from 8/22/13 to 9/30/13 to ensure no trends were identified and then will review monthly.</p> <p>Ice Passes will be monitored 2 X weekly X 4 weeks beginning 8/22/13 to ensure hand washing has occurred correctly.</p> <p>4. The QA team (to include the Maintenance and House Keeping directors, DON, ADM, SSD, Medical Director, ADON, DM) will review all audit findings and make revisions where needed to ensure compliance each week for 2 weeks beginning 8/19/13 and then monthly as needed or until resolved.</p> <p>5. Date of Compliance:: 8/25/2013</p> | | |

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

PRINTED: 08/08/2013
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 07/25/2013 |
|--|---|--|---|----------------------|--|
| 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 4</p> <p>place the blood glucose monitoring device on one paper towel, wash/sanitize their hands, apply gloves, and then proceed to clean the blood glucose monitoring device for two minutes with a chlorine wipe. The staff was required to place the blood glucose monitoring device on a clean paper towel, remove their gloves, wash/sanitize their hands, apply clean gloves, and obtain the blood glucose sample. The policy revealed staff was then required to discard the used supplies, remove their gloves, and wash/sanitize their hands. The staff was then required to apply clean gloves and reclean the blood glucose monitoring device with a chlorine wipe, remove their gloves, and wash/sanitize their hands.</p> <p>Observation of blood glucose monitoring for Resident #11 on 07/23/13, at 5:07 PM, revealed Registered Nurse (RN) #1 washed/sanitized her hands, applied gloves, cleansed the blood glucose monitoring device with a chlorine wipe, discarded the wipe in the trash, and proceeded to perform the blood glucose monitoring on Resident #11 without removing her gloves and washing/sanitizing her hands prior to performing the test.</p> <p>An interview conducted with RN #1 on 07/25/13, at 2:35 PM, revealed she was required to change her gloves and wash/sanitize her hands after cleaning the blood glucose monitoring device and prior to performing the test on Resident # 11. The RN stated she had been "nervous."</p> <p>An interview conducted with the DON on 07/25/13, at 3:40 PM, revealed staff was required to wash/sanitize their hands after cleaning a blood glucose monitoring device and prior to performing a blood glucose monitoring test. The</p> | F 441 | | | |

| 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 07/25/2013 |
|---|---|---|---|----------------------|---|
| 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 | Continued From page 5 DON revealed she made rounds and had randomly monitored nursing staff to ensure staff was performing handwashing and correct technique when performing blood glucose monitoring. The DON stated all nurses were required to have a quarterly skills check for blood glucose monitoring with RN #1 having completed a skills check on 04/15/13. The DON stated she had not identified any issues with blood glucose monitoring. | F 441 | | | |

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

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 _____ | | RECEIVED AUG 16 2013 07/24/2013 | (X3) DATE SURVEY COMPLETED |
| 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 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 07/24/13. 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. Deficiencies were cited with the highest deficiency identified at "F" level. | K 000 | | | | |
| K 052 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is | K 052 | | | | |

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

Roy J. Baber

TITLE

Administrator

(X6) DATE

8/16/13

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

| | | | | | |
|--|--|--|---|----------------------|--|
| 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 07/24/2013 |
| 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 052 | <p>Continued From page 1</p> <p>installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required 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 86 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 07/24/13, at 1:25 PM with the Director of Maintenance (DOM), a test of the facility fire alarm system revealed the fire/smoke barrier doors would close when the alarm was activated but could be reset while in the silent mode to the open position while the system was still showing fire conditions.</p> <p>An interview with the DOM on 7/24/13, at 1:25 PM revealed the DOM was not aware the fire/smoke barrier doors could be reset while the</p> | K 052 | <p>K 052</p> <ol style="list-style-type: none"> 1. No resident was specifically identified All resident have the potential to be affected. 2. All fire/smoke barrier doors were tested to ensure working properly on 8/24/13. The DOM was aware that the barrier doors could be reset to the open position while the system was still showing fire conditions as of 8/24/2013. 3. The Administrator and DOM will monitor once weekly for 3 weeks to ensure all barrier doors close properly when the alarm is enacted, that the hold-open release and closure devices used for release service are monitored for integrity. This monitoring to be initiated the week of 8/12/2013. 4. The QA committee (to include the Maintenance and House Keeping directors, DON, ADM, SSD, Medical Director, ADON, DM) will review all audit findings where needed to ensure compliance each week for 3 weeks beginning 8/19/2013 and then monthly as needed or until resolved. 5. Date of Compliance: 8/25/2013 | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 07/24/2013 |
|--|--|--|---|--|
| 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 052 | Continued From page 2 fire alarm system was still showing fire conditions. The findings were revealed to the Administrator upon exit. Reference: NFPA 72 (1999 Edition). | K 052 | | |
| K 062 SS=F | 3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain their sprinkler system by NFPA standards. This deficient practice affected seven of seven smoke compartments, staff, and all of the residents. The facility has the capacity for 92 beds with a census of 86 on the day of the survey. The findings include: During the Life Safety Code tour on 07/24/13 at 2:45 PM, with the Director of Maintenance (DOM), a record review revealed the facility's fire sprinkler system's interior pipe inspection was last completed in April 2008. This inspection is | K 062 | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 07/24/2013 |
|--|---|--|---|--|
| 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 062 | <p>Continued From page 3 due every five years.</p> <p>An interview with the DOM on 07/24/13 at 2:45 PM, revealed he was unaware the sprinkler system was due an interior pipe inspection.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> | K 062 | <p>K 062</p> <ol style="list-style-type: none"> 1 No resident was specifically identified. All residents have the potential to be affected. 2 The DOM was aware of the requirement of the 5 year inspection for the interior pipe inspection of the sprinkler system as of 8/24/2013. Contact was made on 8/24/2013 with a certified sprinkler system contractor to conduct the required internal inspection of the sprinkler system. The inspection was scheduled to be completed by 8/1/2013. 3 The DOM will log the inspection and keep record of same in his routine maintenance log/binder. The Administrator will monitor to ensure compliance of inspections. 4 The QA committee (to include the Maintenance and House Keeping directors, DON, ADM SSD, Medical Director, ADON, DM) will review any audit findings and make revisions were needed for 2 weeks beginning 8/19/2013. And then monthly as needed or until resolved. 5. Date of Compliance: 8/25/2013 | |