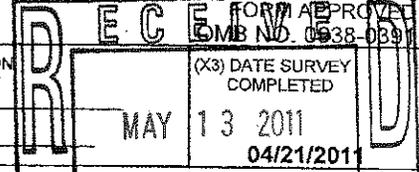


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/03/2011



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 MAY 13 2011 04/21/2011
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE Richmond, KY 40477 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
F 000	INITIAL COMMENTS A standard health survey was conducted on April 19-21, 2011. Deficient practice was cited at "D" level.	F 000		
F 253 SS=D	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 and interviews, it was determined the facility failed to provide services to maintain a medication cart located on the A Wing of the facility in a sanitary manner. Observations of the medication cart revealed the cart was soiled and needed to be cleaned. The findings include: An interview conducted on April 21, 2011, at 2:15 p.m., with the Unit Manager of the A/B Unit revealed the facility did not have a policy for cleaning of the medication cart. The Unit Manager stated, "There are written rules on each medication cart to be followed by each shift. The staff member assigned to the medication cart is responsible for emptying the trash and cleaning the medication cart after every medication pass and at the end of every shift." A medication cart used by facility staff to dispense medications to residents on the A Hall	F 253 F253	1.No specific residents were identified. All residents have the potential to be affected. 2.A one time audit of all medication carts was completed by the DON/ADON(Assistant Director of Nursing) and UM(Unit Manager) on 5/13/2011 to identify any carts that were dirty. Any issues found were immediately corrected. 3.E.T.D.(Education Training Director) to re educate all Licensed Personnel and Certified Medication Techs regarding cleaning the medication carts anytime it is visibly soiled and at least after each medication pass by 5/23/2011. U.M. to audit medication carts on each unit one(1) time a day five(5) times a week for two(2) weeks then one(1) time a week beginning 5/30/2011 to ensure cleanliness. DON/Designee to audit at least two(2) medication carts two (2) times a week beginning 5/16/2011 then randomly one(1) time a week to ensure cleanliness beginning week of 5/30/2011. 4.QA Committee to review all audit findings and revise plan as needed one(1) time a week for 2 weeks beginning week of 5/24/2011 and then one (1) time a month. 5.Date of Compliance 6/3/2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ray T. Baber TITLE: Administrator (X6) DATE: 5/13/11

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

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NAME OF PROVIDER OR SUPPLIER MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
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F 253	Continued From page 1 was observed on April 21, 2011, at 2:00 p.m., to have an orange, sticky substance in the right lower drawer. The drawer contained medications for residents. Also, the middle drawers of the medication cart were observed to have an accumulation of pill residue and debris. An interview on April 21, 2011, at 2:00 p.m., with the Licensed Practical Nurse (LPN) revealed the LPN had administered medications from the medication cart to residents on the A Hall on April 21, 2011. The LPN stated the medication cart should have been cleaned following the medication pass. However, according to the LPN, there had not been sufficient time to clean the cart following the medication pass on April 21, 2011.	F 253			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280			

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F 280	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review/revise the plan of care for one of nineteen sampled residents (resident #10). Resident #10 made statements to staff indicating thoughts of suicide, however, there was no evidence the facility reviewed/revise the resident's care plan to address the suicidal verbalizations. The findings include: The facility had no policy related to residents who voiced suicidal ideations. A record review of resident #10 revealed the resident was admitted to the facility on October 4, 2010, with the following diagnoses: Senile Psychosis, Anxiety Disorder, Depression, Hypertension, Gastroesophageal Reflux Disease, Diabetes Mellitus, Hyperlipidemia, and Dementia. Review of the nursing notes dated January 2, 2011, at 1:00 p.m., revealed a Certified Nursing Assistant (CNA) had reported to the nurse that the resident had stated he/she was going to kill him/herself, and had an idea of how to do the job. According to the nursing notes, the nurse assessed the resident and the resident denied suicidal thoughts and denied making statements to the CNA. The nurse documented that the resident's room was assessed for environmental hazards, and the Director of Nursing (DON) and the Social Services Director (SSD) had been	F 280	F280 1. Resident #10 plan of care was updated by the I.D.T (Interdisciplinary team) on 4/20/2011. Physician and family was notified of Resident #10 plan of care and all issues identified by the U.M on 4/20/2011.No new orders noted. 2.DON/ADON/UM and Social Services Director to review all care plans to identify any plan of care that requires changes and maintained to meet each residents individual needs by 5/30/2011. DON/ADON/UM to review Nurses notes from 2/01/2011 to present to identify any documentation that suggests and/or states suicidal ideations by 5/30/2011. Any issues identified will be immediately corrected by the team. 3.E.T.D to re educate IDT regarding policy to update all care plans when changes occur to meet residents individual needs by 5/16/2011. E.T.D to re educate nursing staff regarding policy for updating plan of care and maintaining plan of care to meet residents individual needs by 5/22/2011. RDGS to re educate IDT which includes DON/ADON/UM/SSD(Social Services Director),Life Enrichment Director and NSM(Nutrition Services Director) regarding EHSI policy for residents voicing suicidal ideations by 5/15/2011. ETD to re educate nursing staff regarding reporting statements of suicidal ideations and policy for plan of care updates per policy by 5/22/2011.	

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F 280	<p>Continued From page 3 notified.</p> <p>Review of the plan of care for resident #10 revealed the plan of care had been reviewed/ revised on February 9, 2011, 38 days after the resident had reportedly expressed suicidal threats to the nurse aide. However, there was no evidence the resident's suicidal threats had been addressed in the plan of care.</p> <p>Interview on April 21, 2011, at 4:35 p.m., with CNA #1 revealed resident #10 had threatened suicide on one occasion. According to CNA #1, the CNA reported the resident's suicidal threats to the nurse on duty.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on April 21, 2011, at 1:35 p.m., revealed the LPN was on duty the day resident #10 voiced suicidal ideations. According to LPN #4, he/she spoke with the DON about the incident "a couple of times" and was advised by the DON to talk to the resident. LPN #4 stated resident #10 denied making a suicidal threat and, at that point, the LPN telephoned the DON again. LPN #4 stated the DON advised him/her to check the resident's room, to monitor the resident every 15 minutes, and to pass the information on to the next shift. In addition, LPN #4 stated he/she wrote a note to the SSD related to the resident's suicidal threat and put the note in the SSD's "in" box at the facility.</p> <p>Interview with the SSD on April 21, 2011, at 9:35 a.m., revealed the SSD had not been made aware resident #10 had voiced suicidal thoughts until January 19, 2011, 17 days after the resident's thought of suicide. The SSD stated the</p>	F 280	<p>DON/Designee to randomly audit ten(10) records weekly for two (2) weeks beginning week of 5/30/2011 then five (5) records weekly for two (2) weeks on each units by reviewing Nurses notes to ensure any suicidal ideations were reported and any plan of care changes was completed as needed to meet residents individual needs.</p> <p>4. QA Committee to review all audit findings and revise plan as needed one (1) time a week for two(2) weeks beginning week of 5/24/2011 and then one(1) time a month .</p> <p>5. Date of Compliance 6/3/2011.</p>	

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F 280	Continued From page 4 resident had been placed on one to one supervision and had been given a diversional activity. The SSD stated no interdisciplinary team notes had been documented to address the report of suicidal thoughts by resident #10. In addition, the SSD confirmed the plan of care for resident #10 had not been revised/reviewed to address the resident's reported suicidal thoughts. Interview with the DON on April 21, 2011, at 1:35 p.m., revealed the DON did not recall receiving a telephone call regarding the suicidal threats made by resident #10. According to the DON, if the DON had been aware of the resident's threat of suicide, an interdisciplinary team would have discussed the situation and updated the care plan to address any suicidal ideations for resident #10.	F 280		
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 observations, staff interviews, and review of medical records, it was determined the facility failed to ensure one of nineteen sampled residents (resident #12) received medications in accordance with physician's orders. The facility failed to ensure one of nineteen sampled residents (resident #3) received oxygen as ordered by the physician. Resident #3 had a physician's order to receive oxygen at two liters per minute via nasal cannula. The resident was observed to receive oxygen at three liters per minute via nasal cannula.	F 281	F281 1. Resident #12 medication times were reviewed by DON on 4/21/2011 and medications are being given with meals .Both physician and family were notified on 4/21/2011 and no new orders were received. Resident #3 oxygen was set according to physician orders and physician was notified of the setting was on three(3) liters by the RDCS on 4/21/2011. 2.A one time audit of all oxygen settings was completed by the RDCS /DON/UM on 4/21/2011 to identify any oxygen not on setting as ordered by the physician. No other issues were noted. A one time audit of all residents with current orders to have medications given with food was completed by the DON/UM on 4/22/2011 to identify any resident not receiving medications with food. Any issues were immediately corrected by the DON/UM.	

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F 281	<p>Continued From page 5</p> <p>The findings include:</p> <p>1. Review of the medical record of resident #12 revealed the resident had been admitted to the facility on August 21, 2009, with diagnoses that included End Stage Renal Disease. The patient received hemodialysis treatments three times a week.</p> <p>Review of the physician's orders for resident #12 dated December 28, 2010, revealed resident #12 was to receive Renvela (a serum phosphorus binder) 800 milligrams (mg) three times daily with meals. Review of the manufacturer's instructions for Renvela, contained in the package insert, revealed Renvela was a phosphate binder indicated for the control of serum phosphorus in patients with chronic disease on dialysis. The manufacturer's information revealed the medication must be given with meals to be effective.</p> <p>Review of the Medication Administration Record for resident #12 revealed the resident was scheduled to receive Renvela 800 mg at 6:00 a.m., 11:00 a.m., and 5:00 p.m. Documentation by staff revealed the medication had been administered at those times. Review of the facility's meal times revealed the breakfast meal began at 7:30 a.m., one and one-half hours after the Renvela had been administered, the lunch began at 11:30 a.m., one-half hour after the Renvela had been administered, and the evening meal began at 5:30 p.m., one-half hour after the Renvela had been administered.</p> <p>Review of the laboratory results for resident #12</p>	F 281	<p>3.ETD to re educate all licensed personnel regarding following policy on physician orders with focus on medication times, oxygen settings and ensuring that medications that are ordered with food are given with food by 5/22/2011.</p> <p>DON/Designee to randomly audit at least five(5) residents receiving oxygen to ensure setting is correct and physicians orders are followed three (3) times a week for two(2) weeks beginning week of 5/23/2011, then three (3) residents one (1) time a week for two (2) weeks.</p> <p>DON/Designee to audit at least five(5) residents with orders for medications to be given with food and at least one(1) of these residents will be receiving dialysis to ensure medication times are correct according to meal times and are being given with food two (2) times a week for two(2) weeks beginning week of 5/23/2011 then three (3) residents one(1) time a week for two (2) weeks.</p> <p>4.QA Committee to review all audit findings and revise plan as needed one(1) time a week for two(2) weeks beginning week of 5/24/2011 and then one(1) time a month.</p> <p>Date of Compliance 6/3/2011.</p>	

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F 281	<p>Continued From page 6</p> <p>revealed the resident's serum phosphorus level on January 21, 2011, was 4.2 milligrams per deciliter (mg/dL) (reference range 2.6 to 4.5). On February 9, 2011, resident #12's phosphorus level was 6.3 mg/dL and on March 9, 2011, the resident's phosphorus level was 5.1.</p> <p>Interview on April 21, 2011, at 10:40 a.m., with Licensed Practical Nurse (LPN) #1 revealed the LPN was unaware of the reason resident #12 received the drug Renvela. LPN #1 stated the medication was a "dialysis medication." The LPN was unaware of the purpose of the medication or the contraindications/side effects of the medication. The LPN was unaware the medication was ineffective if not given with food. According to LPN #1, staff had a timeframe for administering medications and the medication for resident #12 was not always administered with meals. The LPN reported the medication was sometimes administered before meals or after meals.</p> <p>Interview on April 21, 2011, at 10:15 a.m., with the Unit Manager responsible for resident #12 revealed the Unit Manager was unaware of the indications for the use of Renvela. The Unit Manager was unaware of the contraindications/side effects of the medication.</p> <p>2. Review of the medical record for resident #3 revealed the resident was admitted to the facility on February 3, 2010, with diagnoses to include Diabetes Mellitus, Hypertension Chronic Obstructive Pulmonary Disease, and Emphysema.</p> <p>Review of the physician's orders for resident #3</p>	F 281			

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F 281	Continued From page 7 revealed the physician ordered oxygen for resident #3 to be administered at two liters per minute. Observations of resident #3 at 11:00 a.m., 2:12 p.m., 2:40 p.m., 3:14 p.m., and 4:15 p.m. on April 19, 2011, revealed resident #3's oxygen was administered at three liters per minute. An interview was conducted at 4:20 p.m. on April 19, 2011, with the LPN responsible for monitoring the oxygen administration for resident #3. The LPN stated resident #3's oxygen was ordered to be administered at two liters per minute. The LPN stated the oxygen administration for resident #3 had been monitored by the LPN at approximately 9:30 a.m. on April 19, 2011.	F 281		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure one of nineteen sampled residents (resident #10) received appropriate treatment after expressions of suicidal ideations. Resident #10 made suicidal threats to staff on January 2, 2011; however, there was no evidence of interventions until January 19, 2011, seventeen days after the resident's threat.	F 319		

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F 319	<p>Continued From page 8</p> <p>The findings include:</p> <p>Review of the medical record of resident #10 revealed the resident had been admitted to the facility on October 4, 2010, with the following diagnoses: Senile Psychosis, Anxiety Disorder, Depression, Hypertension, Gastroesophageal Reflux Disease, Diabetes Mellitus, Hyperlipidemia, and Dementia.</p> <p>A review of the nursing notes dated January 2, 2011, at 1:00 p.m., revealed a Certified Nursing Assistant (CNA) had reported to a nurse that resident #3 had stated he/she was going to kill him/herself and had an idea of how to do the job. Documentation in the nursing notes revealed the Director of Nursing (DON) and the Social Services Director (SSD) were notified of the resident's threat.</p> <p>Interview on April 21, 2011, at 1:35 p.m., with LPN #4 revealed the LPN had written a note to the SSD on January 2, 2011, after resident #10 verbalized suicidal thoughts to staff. According to LPN #4, he/she placed the note in the SSD's "in" box in the facility. In addition, the LPN stated he/she had spoken to the DON on the day of the incident "a couple of times" and had been advised to talk to the resident and check the resident's room. According to the LPN, the resident was placed on one to one supervision for the remainder of the shift.</p> <p>A review of documentation revealed the SSD documented on January 5, 2011, three days after resident #10's threat of suicide, that the resident and the resident's family member had requested</p>	F 319	F319		
			<ol style="list-style-type: none"> 1. Resident #10 physician and family was made aware of suicidal ideations again on 4/21/2011 and that the statements were made on 1/2/2011 as well by the UM. No new orders were received. 2. DON/ADON/UM and SSD to audit all records nurses notes from 2/1/2011 through 5/13/2011 to identify any documentation regarding suicidal ideations by 5/30/2011. Any issues identified will be reported to the physician and family immediately and plan of care updated to meet residents individual needs. 3. ETD to re educate licensed personnel regarding policy for suicidal ideations and to report any such statement to the Administrator/DON and to document statements in Care tracker and put on 24 hour report sheet by 5/22/2011. DON/SSD to review Care Tracker behavior report five(5) times a week to follow up on any documentation of suicidal ideations for two(2) weeks and review 24 hour report five(5) times a week per policy for two(2) weeks beginning week of 5/23/2011. 4. QA Committee to review all audit findings and revise plan as needed one(1) time a week for two (2) weeks beginning the week of 5/24/2011 and then one(1) time a month. 5. Date of Compliance 6/3/2011. 		

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F 319	Continued From page 9 a room change for the resident. There was no documentation the SSD had addressed the resident's suicidal threat from January 2, 2011. On January 19, 2011, the SSD documented the resident was agitated and had made a comment that the resident wished he/she had a gun or knife to kill him/herself. Documentation in the progress note revealed the resident was transferred to a psychiatric facility for evaluation. Interview on April 21, 2011, at 9:35 a.m., with the SSD revealed the SSD had not been made aware of the resident's suicidal ideations until January 19, 2011. The SSD confirmed the resident's suicidal threats had not been addressed until January 19, 2011, at which time the resident was transferred to a psychiatric facility. Interview on April 21, 2011, at 1:30 p.m., with the DON revealed the DON did not recall receiving a telephone call regarding resident #10 voicing suicidal threats.	F 319			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to prepare a mechanically altered diet as ordered by the physician for four of nineteen sampled residents. According to the menu spreadsheet, residents on a modified diet (Dysphagia 3 Advanced diet) were to receive cream style or	F 367			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/21/2011
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 367	<p>Continued From page 10</p> <p>pureed corn instead of whole kernel corn at the noon meal on April 19, 2011.</p> <p>The findings include:</p> <p>Review of the menu spreadsheet for the noon meal on April 19, 2011, revealed residents on a Dysphagia 3 Advanced diet were to receive cream style or pureed corn instead of whole kernel corn.</p> <p>Observation of the tray line at 11:42 a.m. on April 19, 2011, revealed dietary staff was preparing trays for residents on a Dysphagia 3 Advanced diet with whole kernel corn. Further observation in the dining room revealed residents #6, #17, #18, and #19 were on a Dysphagia 3 Advanced diet. However, the residents' trays contained whole kernel corn.</p> <p>An interview was conducted at 1:10 p.m. on April 20, 2011, with the dietary staff member responsible for placing food onto resident trays at the noon meal on April 19, 2011. The staff member stated sending the whole kernel corn for the four residents in the dining room had been an oversight. The staff member further reviewed the menu spreadsheet and confirmed the residents on Dysphagia 3 Advanced diets were to receive pureed or cream style corn instead of whole kernel corn.</p>	F 367	F367		
			<ol style="list-style-type: none"> 1. Residents #6, 17, 18 and 19 were given the correct consistency upon discovery that the whole corn was served on 4/19/2011. 2. A one time audit of the tray line was completed by the NSM on 5/13/2011 to identify any foods placed on trays that was not the consistency ordered by the physician. Any issues identified was immediately corrected. 3. DSM re educated dietary staff regarding policy to ensure all residents receive the correct consistency on 4/21/2011. DSM to audit five (5) trays during tray line five (5) times a week for two (2) weeks beginning 5/15/2011 then randomly audit five (5) trays per week for two (2) weeks to ensure proper consistency is served per the physicians order. DON/Designee to audit three(3) trays weekly for two(2) weeks beginning week of 5/23/2011 to ensure consistency is per the physicians order. 4. QA Committee to review all audit findings and revise plan as needed one(1) time a week for two(2) weeks beginning the week of 5/24/2011 and then one(1) time a month. 5. Date of Compliance 6/3/2011. 		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2011
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 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on April 20, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 and found Madison Health and Rehabilitation Center to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.