

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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  An annual survey was conducted on 05/30/12 through 06/01/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest scope/severity of a "D."	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hillside Villa Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE  A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)  This REQUIREMENT Is not met as evidenced by: Based on record review, interview, and review of the facility's policy/procedure, it was determined the facility failed to complete a significant change Minimum Data Set (MDS) assessment to identify improvements in the resident's physical and mental status for one resident (#7), in the selected sample of fifteen residents.  Findings include:	F 274	F274  Resident #7's Significant Change MDS was completed on 06/13/12 and transmitted on 06/20/12 by the MDS Coordinator.  Current residents' charts were reviewed by the Director of Nursing, Assistant Director of Nursing and MDS Coordinator on 06/08/12 to determine if a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol L. Britt TITLE: Administrator (X6) DATE: 06/22/12

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.

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/01/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 274	<p>Continued From page 1</p> <p>A review of the facility's policy/procedure, "CMS's RAI Version 3.0 Manual, Significant Change of Status Assessment," revealed a "significant change" is a decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; is not "self-limiting"; impacts more than one area of the resident's health status; and requires interdisciplinary review and/or revision of the care plan.</p> <p>A record review revealed the facility admitted Resident #7 on 04/08/11 with diagnoses to include Cerebral Vascular Disease, Hemiplegia affecting nondominant side, Urinary Tract Infection, Arthritis, and Spinal Stenosis.</p> <p>A review of the resident's admission MDS, dated 04/15/11, revealed a Brief Interview for Mental Status (BIMS) score of nine (9), and a mood and behavior severity score of ten (10). The resident was totally dependent on staff for bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. He/she had a foley catheter, was non-ambulatory and was incontinent of bowel.</p> <p>A review of the quarterly MDS, dated 01/08/12, revealed the resident to have a BIMS score of twelve (12), and experienced an improvement in mood and behavior with a severity score of zero (0). He/she had improvement and was independent in the areas of bed mobility, locomotion on and off the unit, and only required supervision with ambulation and toilet use. He/she was continent of bowel and bladder.</p>	F 274	<p>significant change of condition has occurred. None were noted.</p> <p>MDS Coordinator was re-educated by RAI Specialist, on 06/15/12 on significant change guidelines per the RAI manual.</p> <p>The MDS Coordinator, Director of Nursing, and Assistant Director of Nursing will review five charts weekly for four weeks and then two charts weekly for three months to determine if the significant change of condition guidelines for MDS completion were met. The Director of Nursing will report results to the Performance Improvement Committee for four months for further review and recommendations.</p> <p>Date of Completion</p>	6/22/12

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/01/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIOE AVENUE MADISONVILLE, KY 42431		
(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 274	Continued From page 2 A review of the annual MDS, dated 04/09/12, revealed the resident maintained all areas of improvement as noted in the quarterly assessment, dated 01/08/12.  An interview with the Social Service/Admission Director, on 05/31/12 at 10:55 AM, revealed during the resident's BIMS interview he/she will occasionally not recall a word. She stated "[he/she] had really improved since admission."  An interview with the MDS Coordinator, on 05/31/12 at 10:30 AM, revealed, after a review of Resident 7's MDS assessments, there was an admission assessment completed and an annual assessment completed; however, the resident obviously required a significant change assessment for improvement, and she stated "I just missed it." No further explanation was provided.	F 274			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  <del>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.</del>  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	F 280	Resident #12's care plan was reviewed and updated by the Director of Nursing on 06/01/12 to reflect current needs, UTI, Bronchitis, use of antibiotics and infection control.  Current residents were reviewed for antibiotic use and change of condition by Director of Nursing, Assistant Director of Nursing and Licensed Nurses on 6/8/12.		

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/01/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431	
(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)
F 280	<p>Continued From page 3</p> <p>legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the resident's comprehensive care plan was revised for one resident (#13), in the selected sample of fifteen residents. There was no evidence of a revised care plan for Resident #13 related to infection control and the need for antibiotics.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Care Plans-Interdisciplinary," dated January 2008, revealed the Interdisciplinary Team (IDT) reviewed each care plan at least quarterly with updates, as necessary.</p> <p>A record review revealed the facility admitted Resident #13 on 10/01/06 with diagnoses to include Congested Heart Failure (CHF), Diabetes Mellitus, and Coronary Artery Disease.</p> <p>A review of the care plan, Urinary Incontinence, dated 03/03/12, and reviewed 05/01/12, revealed staff members were to observe for signs and symptoms of a urinary tract infection (UTI), which may cause urgency.</p> <p>A review of the nurses' notes, dated 05/23/12 at</p>	F 280	<p>Care plans were updated and revised at that time to reflect current needs.</p> <p>Licensed nurses were re-educated by the Staff Development Coordinator, Director of Nursing and Assistant Director of Nursing on 06/11/12 regarding revisions and updates of residents' care plans to include infection control practices and antibiotic use.</p> <p>The Director of Nursing and Assistant Director of Nursing will review five care plans weekly for four weeks, then two care plans a month for three months to determine care plans are updated to include infection control and antibiotic use and meet the residents current care needs. The Director of Nursing will report results to the Performance Improvement Committee for four months for further review and recommendations.</p> <p>Date of Completion 6/22/12</p>

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/01/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431		
(X4) IO 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 280	<p>Continued From page 4</p> <p>8:30 AM, revealed the resident voiced a complaint about having shortness of breath and painful urination. A review of the physician's orders, dated 05/23/12, revealed an order for Cefin (antibiotic prescribed for Bronchitis), a urinalysis and culture and sensitivity, and a chest x-ray. A review of the laboratory values and x-ray results, dated 05/23/12, revealed the resident had a UTI and Chronic Bronchitis. However, there was no evidence of a care plan, with measurable objectives to meet the resident's needs for the UTI, or for the use and monitoring of antibiotics and infection control.</p> <p>An interview with Licansed Practical Nurse (LPN) #1, on 06/01/12 at 11:15 AM, revealed there was no care plan for the UTI or for the use of antibiotics. LPN #1 stated the charge nurse, who received the order for the antibiotic from the physician, was responsible for updating the care plan.</p> <p>An interview with the Assistant Director of Nursing (ADON) and Infection Control Nurse, on 06/01/12 at 11:30 AM, revealed the care plen was not revised to include the UTI or the use of antibiotics. The ADON stated, when the resident was started on an antibiotic, the licensed nurse was to complete a Resident Infection Report and send the report to the ADON, for tracking purposes. The licensed staff were suppose to review and revise the care plan, to include monitoring for the infection and antibiotic use, and complete the necessary documentation, In the nurses' notes. She revealed she was unsure why the review and revision of the care plan was not completed.</p>	F 280			

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1969</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (222)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke and heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/30/12. Hillside Care and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carol L. Britt* TITLE *Administrator* (X5) DATE *06/22/12*

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.

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431		
(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	Continued From page 1	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hillside Villa Care &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>		
K 017 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>This STANDARD Is not met as evidenced by: Based on observation and interview, the facility failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.</p>	K 017		<p>The oxygen storage area was removed from the exit corridor for the laundry area by the Maintenance Supervisor on 05/31/12.</p> <p>The Maintenance Supervisor completed a facility inspection of exit corridors on 06/08/12 with no changes needed.</p> <p>The Maintenance Supervisor was re-educated that corridors shall be separated by partitions complying with NFPA</p>	

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 017	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observation, on 05/30/12 at 11:30 AM, with the Maintenance Supervisor revealed an oxygen storage area that was part of the exit corridor for the laundry. The contents of this room are not permitted to be in an area open to the corridor.</p> <p>Interview, on 05/30/12 at 11:30 AM, with the Maintenance Supervisor revealed he was not aware that an oxygen storage area could not be part of the exit corridor.</p> <p>NFPA 101 (2000) 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is</p>	K 017	<p>guidelines and proper storage of medical gases by Administrator on 06/01/12.</p> <p>The Maintenance Supervisor will conduct exit corridor audits for three months and report findings to the Performance Improvement Committee for further recommendations for three months.</p> <p>Completion date</p>	07/13/12
-------	---	-------	--	----------

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431	
(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 017	Continued From page 3 arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits.  7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.	K 017		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.	K 025	K025  The barriers will be properly sealed with fire caulk and smoke barrier foam by Maintenance Supervisor to ensure they resist smoke per NFPA101 Standards by 7/13/12.  The Maintenance Supervisor completed inspection of smoke barriers on 6/8/12 with no concerns noted.  The Maintenance Supervisor was re-educated on NFPA smoke barrier regulations by the Administrator on 06/01/12.  Maintenance Supervisor will conduct inspections of facility smoke barriers quarterly to ensure no new penetrations and report findings to the Performance Improvement Committee quarterly for six months for further recommendations.  Completion date	07/13/12

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING .01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIOE AVENUE MADISONVILLE, KY 42431
---	--

(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 025	Continued From page 4  The findings include:  Observation, on 05/30/12 between 9:00 AM and 9:40 AM, with the Maintenance Supervisor revealed the smoke partitions, extending above the ceiling located throughout the facility, were not properly sealed. The barriers failed to be properly sealed from piping and wires.  Interview, on 05/30/12 between 9:00 AM end 9:40 AM, with the Maintenance Supervisor revealed he was not aware of the penetrations in the smoke barriers.  This is a repeat deficiency.  Reference: NFPA 101 (2000 Edition).  8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose.	K 025		
-------	---	-------	--	--

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIOE AVENUE MADISONVILLE, KY 42431		
(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 025	Continued From page 5 (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025			
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, It was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.  The findings include:  Observation, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor revealed the cross-corridor doors located	K 027	K027  Door Coordinators will be installed on the three sets of smoke barrier doors to ensure they meet NFPA 101 standards by the Maintenance Supervisor by 7/13/12.  The Maintenance Supervisor completed facility inspection of smoke barrier doors on 06/08/12 and door coordinators will be installed to those doors to ensure they meet NFPA101 standards.  Maintenance Supervisor was re-educated on door openings in smoke barriers per NFPA by Administrator on 06/01/12.  Maintenance Supervisor will inspect the facility door coordinators on a quarterly basis and report findings to Performance Improvement Committee quarterly for six months for further recommendations.  Completion date	07/13/12	

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 027	<p>Continued From page 6</p> <p>throughout the facility would not close completely when tested. This was due to the doors not having a coordinating device to ensure the door without the t-astragal would close first after the initial close.</p> <p>Interview, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor revealed he was unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p> <p>NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition)</p> <p>2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation</p>	K 027		

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 027 Continued From page 7  
and shall be without undercuts, louvers, or grilles.  
K 029 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.

The findings include:

Observation, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor revealed the medical records office, the Med room on Wing 2, and the Maintenance/Janitor office need a closer added to the door due to the

K 027

K 029 K029

Automatic door closers were installed by the Maintenance Supervisor on Wing 2 Med Room, Maintenance office and Medical Records office on 06/11/12.

The Maintenance Supervisor completed a facility inspection for hazardous areas on 06/11/12 and no other doors were found to need automatic door closers.

Maintenance Supervisor was re-educated on the need of automatic door closers in hazardous areas by the Administrator on 06/01/12.

The Maintenance Supervisor will inspect the facility for protection of hazards and need for automatic door closures on a quarterly basis and report findings to Performance Improvement Committee quarterly for six months for further recommendations.

Completion date

07/13/12

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 029	<p>Continued From page 8 storage of combustibles inside the areas.</p> <p>Interview, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous</p>	K 029		
-------	--	-------	--	--

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 029	Continued From page 9 by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			
K 040 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure exit discharge doors opened in the direction of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.  The findings include:  Observation, on 05/30/12 at 1:15 PM, with the Maintenance Supervisor revealed the exit gate from the television room did not swing outward. The gate would have to be pulled against egress travel in the event of an evacuation.  Interview, on 05/30/12 at 1:15 PM, with the	K 040	K040 Court yard exit gate hinges were reversed on 06/08/12 to allow gate to open in the direction of egress by the Maintenance Supervisor.  Maintenance Supervisor completed inspection of facility on 06/08/12 and found no other egress issues.  Maintenance Supervisor was re-educated on the exit access doors to open in the direction of egress per NFPA regulations on 06/01/12 by the administrator.  The Maintenance Supervisor will inspect the facility exit egress on a quarterly basis and report findings to Performance Improvement Committee quarterly for six months for further recommendations.  Compliance date	07/13/12	

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431	
(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 040	Continued From page 10 Maintenance Supervisor revealed he was not aware the exit discharge gate needed to open in the direction of egress.	K 040		
K 056 SS=E	NFPA 101 (2000 edition) 7.2.1.4.3 A door shall swing in the direction of egress travel where used in an exit enclosure or where serving a high hazard contents area, unless it is a door from an individual living unit that opens directly into an exit enclosure.  NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one	K 056  K 056	K056  Sprinklers will be installed in the switch gear room and the Wing 2 TV room closet by Armor Fire Protection. Wing I shower rooms sprinkler heads will be replaced with quick response type by Armor Fire Protection. Wing 2 dining room, will have four sprinkler heads replaced with bulbs of the same size by Armor Fire Protection  Maintenance Supervisor completed facility inspection on 06/08/12 to ensure all other compartments did have proper sprinkler protection.  Maintenance Supervisor was re-educated on 06/01/12 by the Administrator on the sprinkler system requirements per NFPA.  The Maintenance Supervisor will inspect the facility for proper sprinkler protection on a quarterly basis and report findings to Performance Improvement Committee quarterly for six months for further recommendations.  Completion date	07/13/12

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 056	Continued From page 11 (71) beds with a census of fifty eight (58) on the day of the survey.  The findings include:  Observation, on 05/30/12 between 10:30 AM and 2:00 PM, with the Maintenance Supervisor revealed a closet in the television viewing room that did not have sprinkler protection. Further observation showed that the old generator room, also known as the switchgear room, was not sprinkler protected. To be fully sprinkled every room of a facility must be sprinkled.  Interview, on 05/30/12 between 10:30 AM and 2:00 PM, with the Maintenance Supervisor revealed he was not aware that the areas listed did not have proper sprinkler protection.  Observation, on 05/30/12 between 10:30 AM and 2:30 PM, with the Maintenance Supervisor revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment located in both shower rooms on Wing 1. Further observation showed mixed sprinkler heads in the Dining area on Wing 2. The bulbs were different sized which means they will most likely have a different response time.  Interview, on 05/30/12 between 10:30 AM and 2:30 PM, with the Maintenance Supervisor revealed he was aware that the sprinklers had to have the same response time if the sprinkler heads are located in the same compartment but he had only been there 4 months and had not had time to get them changed yet.	K 056			

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 056	Continued From page 12  Reference: NFPA 13 (1999 Edition) 5-13.8.1  Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.  Reference: NFPA 13 (1999 Edition)  7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the	K 056		
-------	--	-------	--	--

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROMOTER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 056	Continued From page 13 density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 056		
K 062 SS=F	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 observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency	K 062	K062  All items and shelves were removed from Medical Records office and walk in freezer in Dietary on 05/31/12 by the Maintenance Supervisor. The Maintenance Supervisor will remove the top shelves in resident room closets by 07/13/12	

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 14</p> <p>had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor revealed the freezer and the medical records closet had storage within 18 " of the sprinkler. Further observation showed that the resident closets had a top shelf that had storage within 18 " of sprinkler throughout the facility.</p> <p>Interview, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor revealed he was aware of the distance requirement from sprinkler heads but was not aware the closet shelves in the resident rooms had storage within 18 " of sprinkler heads..</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be</p>	K 062	<p>The Maintenance Supervisor completed facility inspection on 06/08/12 to ensure nothing was stored within 18" of sprinkler heads. No concerns were noted.</p> <p>The Maintenance Supervisor was re-educated on 06/01/12 by Administrator, and the staff were re-educated by Maintenance Supervisor and Staff Development Coordinator on 06/22/12 on the 18" distance requirement from sprinkler heads to stored items</p> <p>Maintenance Supervisor will inspect facility monthly for three months for 18" sprinkler clearance to report findings to Performance Improvement Committee for three months for further recommendations.</p> <p>Completion date</p>	07/13/12	

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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	Continued From page 15 permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.	K 062		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in	K 070	Space heaters were removed from Therapy area by Therapy Program Manager and Social Service office by Licensed Social Worker on 05/30/12.	

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 070	<p>Continued From page 16</p> <p>non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/30/12 between 1:15 PM and 3:00 PM, with the Maintenance Supervisor revealed a portable space heater located in the Therapy area and the Social Services Office.</p> <p>Interview, on 05/30/12 between 1:15 PM and 3:00 PM, with the Maintenance Supervisor revealed he was not aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall</p>	K 070	<p>The Maintenance Supervisor completed facility inspection on 05/30/12 to ensure no other space heaters were in use and no other space heaters were in the facility.</p> <p>The Maintenance Supervisor, Therapy Program Director and Licensed Social Worker were re-educated on regulations concerning the prohibition of space heaters in the facility by the Administrator on 06/01/12.</p> <p>Maintenance Supervisor will inspect facility monthly for three months for space heater usage and report findings to Performance Improvement Committee for three months for further recommendations.</p> <p>Completion date</p>	07/13/12

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 070	Continued From page 17 be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).  Reference: NFPA 13 (1999 edition) 4-2.5.2 Valve rooms shall be lighted and heated. The source of heat shall be of a permanently installed type. Heat tape shall not be used in lieu of heated valve enclosures to protect the dry pipe valve and supply pipe against freezing.	K 070			
K 135 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.  This STANDARD is not met as evidenced by: Based on observation and staff interviews conducted on 05/30/12, it was determined the facility failed to properly store flammable and combustible liquids in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments,	K 135	K135  Flammable spray scents cans were removed from Maintenance office and placed in outside storage building on 05/30/12 by the Maintenance Supervisor.  The Maintenance Supervisor completed facility inspection on 05/30/12 to ensure no other flammable materials were stored in the facility. No concerns noted.  Maintenance Supervisor was re-educated by Administrator on 06/01/12 concerning proper storage of flammable materials and combustible liquids.		

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

PRINTED: 08/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 135	<p>Continued From page 18</p> <p>residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/30/12 at 10:56 AM, with the Maintenance Supervisor revealed five cans of Spray Scents. These items were stored on a shelf in the Maintenance/Janitor Office. The label on the above items stated a level 4 which was severely flammable. All flammable materials shall be stored in a flammable proof cabinet if stored in the facility.</p> <p>Interview, on 05/30/12 at 10:56 AM, with the Maintenance Supervisor revealed he was unaware the spray can were flammable and confirmed the label stated the severe flammable rating.</p> <p>NFPA 99 10-7.2.1* Flammable and Combustible liquids shall be used from and stored in approved containers in accordance with, NFPA 30- 4.3.3</p> <p>Storage cabinets that meet at least one of the following sets of requirements shall be acceptable for storage of liquids: (a) Storage cabinets that are designed and constructed to limit the internal temperature at the center of the cabinet and 1 in. (25 mm) from the top of the cabinet to not more than 325°F (162.8°C), when subjected to a 10-minute fire test that simulates the fire exposure of the standard time-temperature curve specified in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, shall be</p>	K 135	<p>Maintenance Supervisor will inspect facility monthly for three months for flammable materials and report findings to Performance Improvement Committee for three months for further recommendations.</p> <p>Completion date</p>	07/13/12
-------	--	-------	--	----------

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 135	Continued From page 19 acceptable. All joints and seams shall remain tight and the door shall remain securely closed during the test.	K 135		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.  The findings include:  Observations, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor revealed:  1) Open junction boxes in the attic above the 400 hall. 2) An extension cord was being used in the laundry area for the soap dispensers. 3) An electrical panel in the laundry area had a refrigerator stored within 3 feet of the panel. 4) An extension cord was plugged into a television and a fan in room# 109. 5) An electrical panel had storage within 3 feet in the medical records closet.	K 147	K147  Open junction boxes in attic above the 400 hall were covered with approved plate on 06/11/12. Extension cord was removed from resident room 109 and washer detergent dispenser in laundry room on 05/30/12. Refrigerator was relocated at more than 3' from electrical panel on 07/13/12. Storage in Medical Records closet was moved more than 3' from electrical panel on 05/31/12. Copy machine in business office was relocated more than 3' from electrical panel on 06/19/12. All completed by Maintenance Supervisor on dates mentioned.  The Maintenance Supervisor completed facility inspection on 06/01/12 for extension cords in use, blocked or 3' storage around electrical panels and open junction boxes. No concerns noted.  Maintenance Supervisor was re-educated by Administrator on 06/01/12 to ensure compliance with NFPA70 Electrical Code.	

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 147	Continued From page 20 6) An electrical panel was blocked by the copying machine in the business office area.  Interview, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor revealed he was not aware the extension cords were in use. He was also not aware of the storage in front of the electrical panels, or the open junction boxes in the attic.  Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D  Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.  Reference: NFPA 99 (1999 edition) 110-26. Spaces  10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for	K 147	Maintenance Supervisor will inspect facility monthly for three months that electrical wiring and equipment is in accordance with NFPA 70 and report findings to Performance Improvement Committee for three months for further recommendations.  Completion date	07/13/12	

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 147	Continued From page 21 equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Table 110.26(A)(1) Working Spaces  Nominal Voltage to Ground    Minimum Clear Distance Condition 1    Condition 2    Condition 3 0-150 900 mm (3 ft)    900 mm (3 ft)    900 mm (3 ft) 151-600    900 mm (3 ft)    1 m (3½ ft) 1.2 m (4 ft) Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.  (a) Dead-Front Assemblies. Working space shall	K 147		
-------	--	-------	--	--

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  06/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 147	<p>Continued From page 22</p> <p>not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.</p> <p>(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.</p> <p>(c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation.</p> <p>(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.</p> <p>(3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted</p>	K 147		

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 147	Continued From page 23 to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 810 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition.	K 147			

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 147 Continued From page 24

(D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.  
Reference: NFPA 70 (1999 edition)

370.28(c) Covers.

All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.

K 211 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F

Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:

- o The corridor is at least 6 feet wide
- o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)
- o The dispensers have a minimum spacing of 4 ft from each other
- o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.
- o Dispensers are not installed over or adjacent to an ignition source.
- o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100,

K 147

K 211

K211

Alcohol Based Hand Rub Dispensers will be relocated by 07/13/12 away from an ignition source, not adjacent or over an ignition source by NCS, Inc.

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431	
(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 211	Continued From page 25 460.72, 482.41, 483.70, 483.623, 485.623  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of fifty eight (58) on the day of the survey.  The findings include:  Observation, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor revealed Alcohol Based Hand Rub Dispensers were installed over or adjacent to the light switches throughout the facility. Some examples of this deficient practice were in rooms# 400, 406, 416, 408, 415, 411, 302, and 102. Further observation showed the therapy area, the staff lounge, and the maintenance/janitor office also had improperly mounted dispensers.  Interview, on 05/30/12 between 10:30 AM and 3:15 PM, with the Maintenance Supervisor	K 211	The Maintenance Supervisor completed a facility inspection on 06/08/12 for Alcohol Based Hand Rub Dispensers located over or adjacent an ignition source. No concerns noted.  Maintenance Supervisor was re-educated by Administrator on 06/01/12 to ensure compliance with NFPA 101 Life Safety Code Standard.  Maintenance Supervisor will inspect facility for three months for Alcohol Based Hand Rub dispensers located adjacent or over an ignition source and report findings to Performance Improvement Committee for three months for further recommendations.  Completion Date	07/13/12

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

PRINTED: 06/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431
---	--

(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 211	Continued From page 26 revealed he was not aware the dispensers were not allowed to be mounted above or adjacent to an ignition source.  Reference: NFPA 101 (2000 Edition)  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		
-------	--	-------	--	--