RECEIVED JUN 2013 OFFICE OF INSPECTOR GENERAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185015 | A. BUILDING _____ B. WING _____ | 05/10/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NHC HEALTHCARE, MADISONVILLE | 419 NORTH SEMINARY ST 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 |
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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted on 05/08/13 through 05/10/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "F". | F 000 | | |
| F 160 SS=B | 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH<br><br>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined the facility failed to ensure a resident fund account for one (1) resident (#18,) not in the selected sample of seventeen (17) residents, was closed within thirty days after the resident's death.<br><br>Findings include:<br><br>An interview with the Director of Nursing (DON,) on 05/09/13 at 4:30 PM, revealed the facility did not have a policy/procedure that addressed resident accounts.<br><br>A review of the facility's Resident Accounts revealed Resident #18 had expired on 02/13/13 and a check to close the account had not been written until 04/25/13. | F 160 | F 160<br><br>It is the policy of NHC Madisonville to convey resident's funds within 30 days to the individual or to a probate jurisdiction administering the resident's estate.<br><br>The personal funds of resident # 18 was refunded on 04/25/13.<br><br>A 100% audit of all personal fund accounts was completed on 05/29/13 with all other resident accounts found to be in order.<br><br>In-service instruction and education was provided to the bookkeeper on 05/31/13 on the disbursement of personal funds within the 30-day time frame. The administrator provided the in-service.<br><br>All resident funds are protected as a result of the in-service and instruction.<br><br>The monitoring of the resident personal funds will be the responsibility of the bookkeeper. The monitoring will be accomplished through weekly review of discharges for residents who have personal fund accounts.<br><br>Overseen and monitored by the bookkeeper a Quality Assurance audit will be conducted beginning in June 2013 and monthly x 2. The findings will be reported to the Quality Assurance Committee. The | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danny Bellamy — TITLE: Admin — (X6) DATE: 6-3-13

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

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| F 160 | Continued From page 1<br>An interview with the Bookkeeper, on 05/10/13 at 4:55 PM, revealed the person who was in charge of Resident Accounts had gone on leave and the mistake was not found until 04/25/13.<br><br>An interview with the Administrator, on 05/10/13 at 5:30 PM, revealed the facility "just missed this" and the temporary worker was not aware the resident's death. | F 160 | monitoring will be continued by the Bookkeeper or as directed by the Quality Assurance Committee. | 06-15-13 |
| F 372 SS=F | 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY<br><br>The facility must dispose of garbage and refuse properly.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to dispose of garbage properly, related to lids on the dumpsters that could not be closed.<br><br>Findings include:<br><br>An observation of the two dumpsters, on 05/10/13 at 4:45 PM, revealed one of two dumpsters had a lid torn completely off of the dumpster and there was no way to fasten down the lids.<br><br>An interview with the Maintenance Director, on 05/10/13 at 5:00 PM, revealed the city was responsible to maintain the containers and the lid had been missing for approximately five months.<br><br>An interview with the Housekeeping Supervisor, on 05/10/13 at 5:10 PM, revealed she had not been made aware of the problem and stated it | F 372 | F 372<br><br>It is the policy of NHC Madisonville to dispose of garbage and refuse properly.<br><br>The missing dumpster lid was replaced on 05/24/13.<br><br>An inspection was made on 05/24/13 of the two dumpsters and both dumpsters are in compliance with lids.<br><br>In-service instruction and education was provided to the Maintenance Director on 05/31/13 on the proper disposal of garbage and refuse. The administrator provided the in-service.<br><br>All residents, staff, and visitors are protected as a result of the in-service and instruction regarding the dumpsters.<br><br>The monitoring of the dumpster lids will be the responsibility of the Maintenance Director. The monitoring will be accomplished through weekly inspection of the dumpster lids. | |

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| F 372 | Continued From page 2 would be fixed. | F 372 | Overseen and monitored by the Maintenance Director a Quality Assurance audit will be conducted beginning in June 2013 and monthly x 2. The findings will be reported to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee. | 6-15-13 |

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| | 185015 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 05/08/2013 |

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| K 000 | INITIAL COMMENTS<br><br>CFR: 42 CFR 483.70(a)<br><br>BUILDING: 01<br><br>PLAN APPROVAL: 1965 Remodeled: 1972<br><br>SURVEY UNDER: 2000 Existing<br><br>FACILITY TYPE: SNF/NF<br><br>TYPE OF STRUCTURE: One (1) story, Type V (111)<br><br>SMOKE COMPARTMENTS: Five (5) smoke compartments<br><br>FIRE ALARM: Complete fire alarm system with heat and smoke detectors<br><br>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.<br><br>GENERATOR: Type II generator. Fuel source is natural gas.<br><br>A standard Life Safety Code survey was conducted on 05/08/13. NHC Healthcare of Madisonville was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety four (94) beds and the census was eighty four (84) on the day of the survey.<br><br>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danny Belcher — TITLE: admr — (X6) DATE: 7-3-13

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

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| K 000 | Continued From page 1<br>Fire)<br><br>Deficiencies were cited with the highest deficiency identified at "F" level. | K 000 | | |
| K 018 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The | K 018 | K 018<br><br>It is the policy of NHC Madisonville to maintain doors with no impediment to the closing of the doors.<br><br>On 05/28/13 the impediments to the closing of the doors were either removed or realigned to allow for the closing of the doors in Room #101, 106, and 118.<br><br>A 100% audit of other doors was checked on 05/29/13 and no impediments were found.<br><br>The administrator conducted in-service education and instruction on 05/31/13 for all housekeeping and nursing staff regarding no impediments to the closing of doors.<br><br>All residents, staff, and visitors are protected by the in-service education and instruction regarding impediments to the closing of doors.<br><br>The monitoring of the door closing impediments will be the responsibility of the Maintenance Director and Housekeeping Supervisor. The monitoring will be accomplished through weekly | |

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| K 018 | Continued From page 2<br>facility is certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey. The facility failed to ensure doors protecting the corridor were not blocked by floor mats or furniture.<br><br>The findings include:<br><br>Observations, on 05/08/13 between 10:00 AM and 4:00 PM with the Maintenance Supervisor, revealed the corridor doors to resident rooms #101, 106, and 118 were blocked from closing by floor mats and furniture.<br><br>Interviews, on 05/08/13 between 10:00 AM and 4:00 PM, with the Maintenance Supervisor revealed he was not aware the doors were blocked from closing.<br><br>Reference: NFPA 101 (2000 edition)<br><br>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.<br>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar | K 018 | inspection of impediments that may interfere with the closing of doors.<br><br>Overseen and monitored by the Maintenance Director a Quality Assurance audit of the center's compliance of doors protecting the corridor will be conducted monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring and training will be continued by the Maintenance Director or as directed by the Quality Assurance Committee. | 6-1-13 |

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| K 018 | Continued From page 3<br>auxiliary spaces that do not contain flammable or combustible materials.<br>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.<br>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with<br><br>19.3.6.3.3*<br>Hold-open devices that release when the door is pushed or pulled shall be permitted.<br><br>A.19.3.6.3.3<br>Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches. | K 018 | | |
| K 025<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 | K 025 | K 025<br><br>It is the policy of NHC Madisonville to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. | |

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| K 025 | Continued From page 4<br>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<br><br>This STANDARD is not met as evidenced by:<br>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 two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for ninety- four (94) beds with a census of eighty-four (84) on the day of the survey.<br><br>The findings include:<br><br>Observations, on 05/08/13 at 10:00 AM with the Maintenance Director, revealed the smoke barrier extending above the ceiling located by the Administrators Office had penetrations of wires. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. This is a repeat deficiency from a survey conducted in 2012.<br><br>Interview, on 05/08/13 at 10:00 AM, with the Maintenance Supervisor revealed he was not aware of the penetration. | K 025 | The penetrations in the specified areas were repaired with approved materials on May 16, 2013. The repair work was completed by a local construction company and overseen by the Maintenance Director.<br><br>The Maintenance Director received instruction and education from the administrator regarding penetration of smoke barriers on 05-31-13.<br><br>As a result of the repairs of the penetrations in the fire compartments, the safety of residents, staff, and visitors are protected.<br><br>The monitoring of the firewall penetrations will be the responsibility of the Maintenance Director. The monitoring will be accomplished through monthly inspection of the firewalls.<br><br>Overseen and monitored by the Maintenance Director a Quality Assurance audit of the center's compliance of fire wall penetrations will be conducted monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee. | 6-1-13 |

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| K 025 | Continued From page 5<br>Interview, on 05/08/13 at 4:06 AM, with the Administrator revealed he was not aware of the penetration.<br><br>Reference: NFPA 101 (2000 Edition).<br><br>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:<br>(a) The space between the penetrating item and the smoke barrier shall<br>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or<br>2. Be protected by an approved device designed for the specific purpose.<br>(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<br>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or<br>2. Be protected by an approved device designed for the specific purpose.<br>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall<br>1. Be made on either side of the smoke barrier, or<br>2. Be made by an approved device designed for the specific purpose. | K 025 | | |
| K 027<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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. | K 027 | K 027<br><br>It is the policy of NHC Madisonville to maintain cross-corridor doors to resist the passage of smoke in accordance with NFPA standards. | |

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| K 027 | Continued From page 6<br>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<br><br>This STANDARD is not met as evidenced by:<br>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 certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey. The facility failed to ensure doors located in a smoke barrier would resist the passage of smoke.<br><br>The findings include:<br><br>Observation, on 05/08/13 between 10:00 AM and 4:00 PM with the Maintenance Supervisor, revealed the cross corridor doors in the smoke barrier located next to the Administrators Office, Laundry, and room #100 had a gap greater than 1/8th of an inch and would not resist the passage of smoke.<br><br>Interview, on 05/08/13 between 10:00 AM and 4:00 PM, with the Maintenance Supervisor revealed he was not aware the doors had a gap too large but would have them adjusted to meet the requirement. | K 027 | A local construction company completed a repair listing on the doors located next to the Administrator's Office, Laundry, and room # 100 on 05-16-13. The repair listing included adjustments to the doors including the installation of new door closers on each door.<br><br>A local contractor installed the door closers on the doors on 06-18-13. Additional materials are on order to complete the repairs of the doors with an expected completion date of 07/30/13. See statement from contractor.<br><br>A 100% inspection was completed of the remaining cross-corridor doors with the remaining doors found to be in compliance with this NFPA standard.<br><br>The administrator conducted in-service education and instruction on 05/31/13 with the Maintenance Director regarding maintenance of cross-corridor doors and the passage of smoke.<br><br>As a result of the repairs to the cross-corridor doors located next to the Administrator's Office, Laundry, and room #100, the safety of residents, staff, and visitors are protected.<br><br>The monitoring of the cross-corridor doors will be the responsibility of the | |

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| K 027 | Continued From page 7<br>Reference: NFPA 101 (2000 edition)<br><br>8.3.4.1* Doors in smoke barriers shall close the opening leaving<br>only the minimum clearance necessary for proper operation<br>and shall be without undercuts, louvers, or grilles.<br><br>Reference: NFPA 80 (1999 Edition)<br>Standard for Fire Doors 2-3.1.7<br>The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors. | K 027 | Maintenance Director. The monitoring will be accomplished through weekly inspection of the cross-corridor doors.<br><br>Overseen and monitored by the Maintenance Director a Quality Assurance audit of the center's compliance of cross-corridor doors will be conducted monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee. | |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>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 | K 029 | K 029<br><br>It is the policy of NHC Madisonville to meet the requirements of Protection of Hazards in accordance with NFPA Standards.<br><br>On 05/29/13 self closing devices were installed on the Business Office door to the Reception Office, Business Office to Social Services, and the Medical Records Office.<br><br>Air vents in the Boiler Room on C Hall and the air vent in the Laundry Room were unblocked on 05/16/29.<br><br>A 100% audit of remaining doors was completed and remaining doors were found to be in compliance. | 6-24-13 |

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|---|---|---|---|
| | 185015 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 05/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NHC HEALTHCARE, MADISONVILLE | 419 NORTH SEMINARY ST<br>MADISONVILLE, KY 42431 |

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| K 029 | Continued From page 8<br>five (5) smoke compartments, residents, staff and visitors. The facility is certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 05/08/13 between 10:00 AM and 4:00 PM with the Maintenance Supervisor, revealed the Business Office door to the Reception Office, Business Office to Social Services, and the Medical Records Office did not have a self-closing device installed on the door. The Business Office and Medical Records Office had large amounts of combustible paper. Further observation revealed fresh air vents located in the Boiler Room of C Hall and an air vent in the Laundry Room were blocked to prevent cold air from entering.<br><br>Interview, on 05/08/13 between 10:00 AM and 4:00 PM, with the Maintenance Supervisor revealed he was not aware the doors to hazardous rooms were required to be self-closing. Further interview revealed he was not aware the vents had been blocked.<br><br>Reference:<br><br>NFPA 101 (2000 Edition).<br><br>18.3.2 Protection from Hazards.<br>18.3.2.1* Hazardous Areas.<br>Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated. | K 029 | A 100% audit of additional air vents was completed and remaining vents were found to be in compliance.<br><br>The administrator conducted in-service education and instruction on 05/31/13 with the Maintenance Director regarding blocked air vents and self-closing door devices in the Business Office.<br><br>As a result of the installation of self-closing devices on the Business Office door to the Reception Office, Business Office to Social Services, and the Medical Records Office, the safety of residents, staff, and visitors are protected.<br><br>As a result of the unblocking of air vents located in the Boiler Room on C hall and in the Laundry, the safety of residents, staff, and visitors are protected<br><br>The monitoring of the self-closing devices will be the responsibility of the Maintenance Director. The monitoring will be accomplished through visual monthly inspection of the self closing devices located on the Business Office door to the Reception Office, Business Office to Social Services, and the Medical Records Office.<br><br>The monitoring of unblocked air vents in the Laundry and in the Boiler Room on C Hall will be the responsibility of the Maintenance Director. The monitoring will be accomplished through weekly inspection of the air vents. | |

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| K 029 | Continued From page 9<br><br>Table 18.3.2.1 Hazardous Area Protection<br><br>Hazardous Area Description<br>Separation/Protection<br>Boiler and fuel-fired heater rooms 1 hour<br>Central/bulk laundries larger than 100 ft2 (9.3 m2) 1 hour<br>Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard See 18.3.6.3.4<br>Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, Standard for Health Care Facilities 1 hour<br>Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard 1 hour<br>Physical plant maintenance shops 1 hour<br>Soiled linen rooms 1 hour<br>Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding<br>100 ft2 (9.3 m2) storing combustible material See 18.3.6.3.4<br>Storage rooms larger than 100 ft2 (9.3 m2) storing combustible<br>material 1 hour<br>Trash collection rooms 1 hour<br><br>19.3.2 Protection from Hazards.<br>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 | K 029 | Overseen and monitored by the Maintenance Director a Quality Assurance audit of the center's compliance of self closing devices located on the Business Office door to the Reception Office, Business Office to Social Services, and the Medical Records Office will be conducted monthly x 2 beginning in June 2013. In addition, an audit will be completed on the center's compliance of blocked air vents monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee. | 6-1-13 |

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| K 029 | Continued From page 10<br>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:<br>(1) Boiler and fuel-fired heater rooms<br>(2) Central/bulk laundries larger than 100 ft2 (9.3 m2)<br>(3) Paint shops<br>(4) Repair shops<br>(5) Soiled linen rooms<br>(6) Trash collection rooms<br>(7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies<br>and equipment in quantities deemed hazardous by the authority having jurisdiction<br>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.<br>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied<br>protective plates extending not more than 48 in. (122 cm) above the bottom of the door.<br><br>Reference: NFPA 101 Life Safety Code (2000 edition)<br><br>Section 19.5 Building Services<br><br>19.5.2.2<br>Any heating device other than a central heating plant shall be designed and installed so that | K 029 | | |

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| K 029 | Continued From page 11<br>combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. | K 029 | | |
| K 046 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, and interview it was determined the facility failed to test emergency lighting 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 certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey. The facility failed to test emergency battery lighting for 30 seconds monthly and 90 minutes annually.<br><br>The findings include:<br><br>Observation, on 05/08/13 at 11:00 AM, with the Maintenance Supervisor revealed the facility did not have documentation for monthly testing, or the annual testing of emergency battery lighting located in the transfer switch room. | K 046 | K 046<br><br>It is the policy of NHC Madisonville to test emergency lighting in accordance with NFPA standards.<br><br>Beginning on May 16, 2013 written documentation was completed for monthly testing and the annual testing of the emergency battery lighting located in the transfer switch room.<br><br>The testing will document in writing a test at 30 day intervals for not less than 30 seconds. An annual test documented in writing will be conducted for at least 90 minutes for the emergency battery lighting located in the transfer switch room.<br><br>A 100% audit of the building reveals no other emergency battery lighting systems.<br><br>The administrator conducted in-service education and instruction on 05/31/13 with the Maintenance Director regarding testing of emergency battery lighting on a monthly and annual basis. | |

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| K 046 | Continued From page 12<br>Interview, on 05/08/13 at 11:00 AM, with the Maintenance Supervisor revealed he was not aware documentation was to be kept for emergency battery light testing.<br><br>Reference: NFPA 101 (2000 edition)<br>7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.<br><br>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.<br>Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less | K 046 | As a result of the written documentation and testing of the emergency battery lighting system, the safety of residents, staff, and visitors are protected.<br><br>The monitoring of testing and written documentation of the 30 second 30 day interval tests, in addition to the 90 minute annual testing and written documentation testing will be the responsibility of the Maintenance Director. The monitoring will be accomplished through visual monthly inspections of the emergency battery lighting system located in the transfer switch room.<br><br>Overseen and monitored by the Maintenance Director a Quality Assurance audit of the center's compliance of the testing and written documentation of the emergency battery lighting system will be conducted monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee. | 6-1-13 |

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| K 046 | Continued From page 13<br>than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. | K 046 | | |
| K 047 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained 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 certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey. The facility failed to ensure exits in the kitchen were clearly recognizable with proper exit signage.<br><br>The findings include:<br><br>Observation, on 05/08/13 at 2:47 PM with the Maintenance Supervisor, revealed the exits in the Kitchen were not marked with exit signage and not clearly recognizable.<br><br>Interview, on 05/08/13 at 2:47 PM, with the Maintenance Supervisor revealed he was not aware the Kitchen exits did not have proper exit signage. | K 047 | K 047<br><br>It is the policy of NHC Madisonville to maintain exit signs in accordance with NFPA standards.<br><br>On 05/17/13 two clearly recognizable exit signs were installed in the dietary department at the correct exit doors.<br><br>A 100% audit of exit doors was completed on 05/28/13 with all remaining exit doors found to be in compliance.<br><br>The administrator conducted in-service education and instruction on 05/31/13 with the Maintenance Director regarding emergency exit lighting signs in the Dietary Department.<br><br>As a result of the installation of clearly recognizable exit signs in the dietary department, the safety of residents, staff, and visitors are protected.<br><br>The monitoring of the exit signs in the dietary department will be the responsibility of the Maintenance Director. The monitoring will be accomplished through visual monthly inspections of the exit signs. | |

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| K 047 | Continued From page 14<br><br>Reference: NFPA 101 (2000 edition)<br><br>18.2 MEANS OF EGRESS REQUIREMENTS<br>18.2.1 General.<br>Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.<br>Exception: As modified by 18.2.2 through 18.2.11.<br><br>18.2.10 Marking of Means of Egress.<br>18.2.10.1<br>Means of egress shall have signs in accordance with Section 7.10.<br><br>7.10 MARKING OF MEANS OF EGRESS<br>7.10.1 General.<br>7.10.1.1 Where Required.<br>Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42.<br>7.10.1.2* Exits.<br>Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.<br>7.10.1.3 Exit Stair Door Tactile Signage.<br>Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows:<br>EXIT<br>Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the | K 047 | Overseen and monitored by the Maintenance Director, a Quality Assurance audit of the center's compliance of the exit signs in the dietary department will be conducted monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee. | 6-1-13 |

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| K 047 | Continued From page 15<br>centerline of the sign.<br>Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change.<br>7.10.1.4* Exit Access.<br>Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs.<br>Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.<br>7.10.1.5* Floor Proximity Exit Signs.<br>Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame.<br>7.10.1.6* Floor Proximity Egress Path Marking.<br>Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as | K 047 | | |

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| K 047 | Continued From page 16<br>interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. | K 047 | K 050<br><br>It is the policy of NHC Madisonville to conduct fire drills at unexpected random times according to NFPA standards.<br><br>In-service and education was provided to the Maintenance Director by the administrator related to conducting fire drills quarterly on 2nd shift at random times under varied conditions. The education was provided on May 31, 2013<br><br>As a result of the education and compliance with random fire drills under varied conditions the safety of residents, staff, and visitors are protected.<br><br>The monitoring of the random fire drills will be the responsibility of the Maintenance Director. The monitoring will be accomplished through visual inspection of the documentation of the random fire drills on a monthly basis<br><br>Overseen and monitored by the Maintenance Director, a Quality Assurance audit of the center's compliance of the randomness and unexpected time of fire drills on the 2nd shift will be conducted monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring will be continued by the Maintenance Director | |
| K 050 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, 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 certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times on all shift.<br><br>The findings include:<br><br>Fire Drill review, on 05/08/13 at 10:45 AM, with | K 050 | | |

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| K 050 | Continued From page 17<br>the Maintenance Supervisor revealed the facility failed to conduct fire drills at unexpected times on second (2nd) shift. This is a repeat deficiency from a survey conducted in 2012.<br><br>Interview, on 05/08/13 at 10:45 AM, with the Maintenance Supervisor revealed he was not aware the fire drills were not being conducted as required.<br><br>Interview, on 05/08/13 at 4:06 PM, with the Administrator revealed he thought the requirement was referring to the dates of the drills, and not the times.<br><br>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.<br><br>Reference: NFPA 101 Life Safety Code (2000 Edition).<br>19.7* OPERATING FEATURES<br>19.7.1 Evacuation and Relocation Plan and Fire Drills.<br>19.7.1.1<br>The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. | K 050 | or as directed by the Quality Assurance Committee. | 6-1-13 |

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| NHC HEALTHCARE, MADISONVILLE | 419 NORTH SEMINARY ST<br>MADISONVILLE, KY 42431 |

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| K 050 | Continued From page 18<br>The provisions of 19.7.1.2 through 19.7.2.3 shall apply.<br>19.7.1.2*<br>Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.<br>Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. | K 050 | | |
| K 056<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by: | K 056 | K 056<br><br>It is policy of NHC Madisonville to ensure the building has a complete sprinkler system in accordance with NFPA standards.<br><br>On May 17, 2013 a representative from a licensed sprinkler company was at the facility to review the scope of the work required to complete sprinkler coverage to the closets in room #'s 101, 102, 104, 103, 107, 108, 105, 106, 109, 110, 111, 112, 113, 114, 115,117, 116, 118, 119, 120, 121, 122, 123, 124, and 125. The repairs was completed on 06/28/13. | |

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| K 056 | Continued From page 19<br>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 five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for ninety-four (94) certified beds with a census of eighty-four (84) on the day of the survey. The facility failed to ensure the facility had complete sprinkler coverage installed to meet NFPA standards.<br><br>The findings include:<br><br>Observation, on 5/08/13 at between 10:00 AM, with the Maintenance Supervisor revealed closets that do not have adequate sprinkler protection located in rooms# 101, 102, 104, 103, 107, 108, 105, 106, 109, 111, 111, 112, 113, 114, 115, 117, 116, 118, 119, 120, 121, 123, 124, and 125. Further observation revealed the sprinkler riser room did not have a sprinkler head installed in the room.<br><br>Interview, on 5/08/13 between 10:00 AM, with the Maintenance Supervisor revealed he was not aware the rooms did not have adequate sprinkler coverage.<br><br>Reference: NFPA 101 (2000 Edition).<br><br>9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition | K 056 | In addition, the sprinkler company will install a sprinkler head in the riser room. The installation of the sprinkler head in the riser room was completed on 06/28/13.<br><br>The administrator conducted in-service education and instruction on 05/31/13 with the Maintenance Director regarding the closet sprinkler installation in the individual rooms and in the sprinkler riser room.<br><br>As a result of installing sprinklers to provide closet sprinkler coverage in room #'s 101, 102, 104, 103, 107, 108, 105, 106, 109, 110, 111, 112, 113, 114, 115,117, 116, 118, 119, 120, 121, 122, 123, 124, and 125 and installing the sprinkler head in the riser room, the safety of residents, staff, and visitors are protected.<br><br>The monitoring of the sprinklers in the specified rooms and the installation of sprinkler head in the riser room will be the responsibility of the Maintenance Director.<br><br>Overseen and monitored by the Maintenance Director, a Quality Assurance audit of the center's compliance of the sprinkler closet coverage in room #'s 101, 102, 104, 103, 107, 108, 105, 106, 109, 110, 111, 112, 113, 114, 115,117, 116, 118, 119, 120, 121, 122, 123, 124, and 125 and the sprinkler head in the riser room, will be conducted monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring will be continued by the | |

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| K 056 | Continued From page 20<br>that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves.<br>Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.<br><br>Reference: NFPA 13 (1999 Edition) 5-13 8.1<br><br>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.<br>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.<br>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.<br>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:<br>(1) Sprinklers installed throughout the premises<br>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler<br>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to | K 056 | Maintenance Director or as directed by the Quality Assurance Committee.<br><br>K 072 | 6-24-13 |

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| K 056 | Continued From page 21<br>activation time and distribution.<br><br>Reference: NFPA 13 (1999 Edition)<br>5-5.5.2.2 Sprinklers shall be positioned in accordance with<br>the minimum distances and special exceptions of Sections 5-6<br>through 5-11 so that they are located sufficiently away from<br>obstructions such as truss webs and chords, pipes, columns,<br>and fixtures.<br>Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP) | K 056 | | |

| Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B | Maximum Allowable Distance of Deflector Obstruction (in.) |
|---|---|
| Less than 1 ft | 0 |
| 1 ft to less than 1 ft 6 in. | 21/2 |
| 1 ft 6 in. to less than 2 ft | 31/2 |
| 2 ft to less than 2 ft 6 in. | 51/2 |
| 2 ft 6 in. to less than 3 ft | 71/2 |
| 3 ft to less than 3 ft 6 in. | 91/2 |
| 3 ft 6 in. to less than 4 ft | 12 |
| 4 ft to less than 4 ft 6 in. | 14 |
| 4 ft 6 in. to less than 5 ft | 161/2 |
| 5 ft and greater | 18 |

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).
Reference: NFPA 13 (1999 Edition)
5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.

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| K 072 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to maintain exit access 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 certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments.<br><br>The findings include:<br><br>Observations, on 05/08/13 between 10:00 AM and 4:00 PM, with the Maintenance Supervisor revealed linen carts were being stored in the A Hall, B Hall, C Hall, and Round Station Hall. This is a repeat deficiency from a survey conducted in 2012.<br><br>Interview, on 05/08/13 between 10:00 AM and 4:00 PM, with the Maintenance Supervisor revealed linen carts were routinely stored in these areas. Further interview revealed he thought as long as they were moved from one spot to another every thirty minutes it was acceptable for | K 072 | K 072<br><br>It is the policy of NHC Madisonville to maintain exit access in accordance with NFPA standards.<br><br>Linen cabinets are scheduled for installation in locations in the facility for storage of linen. The cabinets are scheduled for installation the week of 07/08/13. See attached statement from the cabinetry vendor.<br><br>In-service instructions and education was given to all direct care staff and licensed staff on May 31, 2013 as to the location of storage of the linen storage cabinets. The administrator presented the in-service.<br><br>As a result of the scheduled installation of linen cabinets, the safety of residents, staff, and visitors are protected.<br><br>The monitoring of egress obstruction will be the responsibility of the Maintenance Director. The monitoring will occur through visual observation to ensure egress is free of impediments. The observations will occur on a daily basis.<br><br>Overseen and monitored by the Maintenance Director, a Quality Assurance audit of the center's compliance with exit access will be conducted monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring will be | |

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| K 072 | Continued From page 23<br>them to stay in the egress path.<br><br>Interview, on 05/08/13 at 4:06 PM, with the Administrator revealed he thought as long as they were moved from one spot to another every thirty minutes it was acceptable for them to stay in the egress path.<br><br>Reference: NFPA 101 (2000 Edition)<br>Means of Egress Reliability 7.1.10.1<br>Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. | K 072 | continued by the Maintenance Director or as directed by the Quality Assurance Committee. | 6-24-13 |
| K 073<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4<br><br>This STANDARD is not met as evidenced by:<br>Based on flame retardant documentation review and interview, it was determined the facility failed to ensure that combustible decorations were used 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 certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey. The facility failed to provide documentation that personal and seasonal decorations had been treated or was flame retardant.<br><br>The findings include: | K 073 | K 073<br><br>It is the policy of NHC Madisonville to ensure that combustible decorations are used in accordance with NFPA standards.<br><br>The process of identifying and 'logging in' combustible decorations was begun on May 28, 2013.<br><br>A 100% audit of all resident rooms for combustible decorations and personal items was completed on May 31, 2013.<br><br>Flame retardant material arrived at the facility on May 28, 2013. The process of applying the flame retardant material was completed on June 21, 2013. Upon application of the flame retardant material on the combustible decorations, documentation is maintained of the treatment date and kept on the treated items.<br><br>In-service instructions and education was given to all direct care staff, licensed staff, and housekeeping staff on May 31, 2013 as | |

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| K 073 | Continued From page 24<br>Flame retardant documentation review, on 05/08/13 at 11:00 AM, with the Maintenance Supervisor revealed the facility did not have documentation that newly introduced personal or seasonal decorations for residents or staff had been treated with a flame retardant material.<br><br>Interview, on 05/08/13 at 11:00 AM with the Maintenance Supervisor, revealed he was not aware decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated.<br><br>Reference: NFPA 101 (2000 Edition)<br><br>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. | K 073 | to the identification of personal items and application of flame retardant material. The administrator presented the in-service.<br><br>All patients, staff, and visitors are protected by the application of flame retardant material on seasonal decorations and personal items.<br><br>The monitoring of flame retardant material will be the responsibility of the Maintenance Director. The monitoring will occur through visual identification of seasonal decorations and personal items to ensure flame retardant material is applied. The observations will occur on a weekly basis. | |
| K 076<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 | K 076 | Overseen and monitored by the Maintenance Director, a Quality Assurance audit of the center's compliance with the application and documentation of flame retardant material will be conducted monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.<br><br>K 076<br><br>It is the policy of NHC Madisonville to ensure oxygen areas are protected in accordance with NFPA standards. | 6-21-13 |

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| K 076 | Continued From page 25<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected 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 certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored in a room with an ignition source not located below five (5) feet from the floor.<br><br>The findings include:<br><br>Observation, on 05/08/13 at 11:57 PM with the Maintenance Supervisor revealed sixty (60) " E " oxygen tanks in the C Hall oxygen storage room. The oxygen storage room had a light switch installed below five (5) feet from the floor.<br><br>Interview, on 05/08/13 at 11:57 PM with the Maintenance Supervisor revealed he was unaware the light switch could not be below five feet.<br><br>Reference:<br>NFPA 101 (2000 edition)<br>8-3.1.11.2<br>Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3)<br>(a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.<br>(b) Oxidizing gases, such as oxygen and nitrous | K 076 | The light switch in the oxygen storage area was blocked on May 16, 2013 to remove the risk of an ignition source. The light switch was blocked and disabled by a local electrical contractor.<br><br>In-service instructions and education was given to the Maintenance Director on May 15, 2013 as to disabling the light switch. The administrator presented the in-service.<br><br>As a result of blocking the light switch, the safety of residents, staff, and visitors are protected.<br><br>The monitoring of the disabled light switch in the oxygen storage room area will be the responsibility of the Maintenance Director. The monitoring will occur through visual observation of the blocked light switch in the oxygen storage are to ensure there is no ignition source. The observations will occur on a weekly basis.<br><br>Overseen and monitored by the Maintenance Director, a Quality Assurance audit of the center's compliance with the blocked light switch will be conducted monthly x 2 beginning in June 2013. The Maintenance Director will visually inspect the blocked light switch monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee. | 6-1-13 |

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| K 076 | Continued From page 26<br>oxide, shall not be stored with any flammable gas, liquid, or vapor.<br>(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:<br>(1) A minimum distance of 6.1 m (20 ft)<br>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems<br>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.<br>(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.<br>(e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.<br>(f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d.<br>(g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13.<br>(h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27.<br>(i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations.<br>(j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14. | K 076 | | |
| K 144<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in | K 144 | K 144<br><br>It is the policy of NHC Madisonville to ensure the emergency generator is maintained in accordance with NFPA standards. | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 144 | Continued From page 27<br>accordance with NFPA 99. 3.4.4.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained 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 certified for ninety-four (94) beds with a census of eighty-four (84) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 05/08/13 at 2:30 PM with the Maintenance Supervisor, revealed storage of oily rags, and bricks in the generator room. Further observation revealed the generator room did not have an emergency battery lighting installed.<br><br>Interview, on 05/08/13 at 2:30 PM, with the Maintenance Supervisor revealed he was not aware items could not be stored in the generator room. Further interview revealed he was not aware emergency battery lighting was required in the generator room.<br><br>Reference: NFPA 110 (1999 Edition). | K 144 | The oily rags and bricks were removed from the generator room on May 13, 2013. Emergency battery lighting was installed in the generator area on May 15, 2013.<br><br>In-service instructions and education was given to the Maintenance Director on May 13, 2013 as to removing the oily rags, bricks, and the emergency battery lighting in the generator area. The administrator presented the in-service<br><br>As a result of removing the oily rags and bricks and installing the emergency battery lighting in the generator room, the safety of residents, staff, and visitors are protected.<br><br>The Maintenance Director will monitor the generator room for clutter and emergency battery lighting through visual inspection on weekly rounds.<br><br>Overseen and monitored by the Maintenance Director, a Quality Assurance audit of the center's compliance with the generator room area and emergency battery lighting will be conducted monthly x 2 beginning in June 2013. The Maintenance Director will visually inspect the generator room area and emergency battery lighting monthly x 2 beginning in June 2013. The findings will be reported to the Quality Assurance Committee. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee. | 5-16-13 |

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|---|---|---|---|
| | 185015 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 05/08/2013 |

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| K 144 | Continued From page 28<br><br>5-12.6<br>The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers ' recommendations and accepted engineering practices.<br>Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.<br><br>Reference: NFPA 99 (1999 Edition).<br><br>3-4.1.1.15 + Alarm Annunciator.<br>A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.)<br>The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:<br>a. Individual visual signals shall indicate the following:<br>1. When the emergency or auxiliary power source is operating to supply power to load<br>2. When the battery charger is malfunctioning<br>b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:<br>1. Low lubricating oil pressure<br>2. Low water temperature (below those required in 3-4.1.1.9)<br>3. Excessive water temperature<br>4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply | K 144 | | |

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| | 185016 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 05/08/2013 |

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| K 144 | Continued From page 29<br>5. Overcrank (failed to start)<br>6. Overspeed<br>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]<br><br>Reference: NFPA 110 (1999 Edition).<br><br>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.<br><br>Reference: NFPA 99 (1999 Edition)<br><br>Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.<br>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1. | K 144 | | |

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| K 144 | Continued From page 30<br>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).<br>Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.<br>Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.<br>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.<br>(b) Inspection and Testing.<br>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.<br>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. | K 144 | | |

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| K 144 | Continued From page 31<br>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.<br>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.<br><br>6-1.1*<br>The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction<br><br>6-3.3<br>A written schedule for routine maintenance and operational testing of the EPSS shall be established<br><br>6-4.1*<br>Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.<br><br>6-4.5<br>Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer | K 144 | | |

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| K 144 | Continued From page 32<br>switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.<br><br>Reference: NFPA 101 ( 2000 edition)<br><br>7.9.1.2 Where maintenance of illumination depends on<br>changing from one energy source to another, a delay of not<br>more than 10 seconds shall be permitted.<br>Reference: NFPA 110 (1999 ed.)<br>5-7 Heating, Cooling, and Ventilating.<br>5-7.1* Consideration shall be given to properly sizing the ventilation<br>or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter,<br>uninsulated or insulated exhaust pipes, and other heat-producing<br>equipment.<br>5-7.2 Adequate ventilation shall be provided to prevent temperatures<br>or temperature rises in the EPS and related accessory<br>equipment that exceed the recommendations of the<br>manufacturer.<br>5-7.3 For the EPS equipment room, the ventilation or cooling<br>equipment, or both, shall be sized so that the ambient temperature<br>shall not exceed the EPS equipment manufacturer ' s criteria<br>or allowable maximum temperatures. | K 144 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| K 144 | Continued From page 33<br><br>Reference: NFPA 110 (1999 Edition)<br><br>5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room. | K 144 | | |