

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/24/2014
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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431
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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
F 000	INITIAL COMMENTS	F 000	F 281	
F 281 SS=D	<p>A Recertification Survey was conducted on 04/22/14 through 04/24/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "F".</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's "Medication Administration General Guidelines" policy/procedure, it was determined the facility failed to ensure services provided met professional standards of quality for one (1) unsampled resident (Resident B). LPN #1 failed to administer Coreg (blood pressure) with food as per the physician's order.</p> <p>The findings include:</p> <p>Review of the "Medication Administration General Guidelines" policy/procedures, dated 10/11, revealed medications were administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.</p> <p>Review of the History & Physical for Resident A, dictated 03/01/14, revealed diagnoses to include Hypertension and Orthostatic Hypotension. Review of the Clinical Pharmacy Review, dated</p>	F 281	<p>It is the policy of NHC Madisonville to provide or arrange services that meet professional standards of quality.</p> <p>The physician orders on Resident B were reviewed by the ADON on 04/22/14. The physician for Resident B was contacted by the ADON on 04/22/14 for review of medications.</p> <p>The blood pressure of Resident B was monitored by licensed nurses every shift x 3 days beginning with 04/22/14 then weekly x 21 days. The blood pressure on Resident B was within normal limits.</p> <p>A 100% audit of blood pressures was completed on all residents from 04/22/14 through 04/27/14. The audit was completed on 06/17/14 by the Licensed Management Team of nurses. The audit revealed all blood pressures being within normal limits therefore no other residents were affected.</p> <p>A 100% audit of physician orders was conducted on all residents by DON, ADON and RN LPN Team Leaders on 04/25/14 with all other physician orders found to be in compliance.</p> <p>In-service instruction and education was provided to RN and LPN staff on 04/28/14 on physician order compliance. The facility does not</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danny Belcher TITLE: adm (X6) DATE: 6-24-14

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

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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
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F 281	Continued From page 1 03/02/14, revealed Coreg was given for Hypertension. Review of the resident's Physician's Orders, dated 03/08/14, and the April 2014 Medication Administration Record (MAR) revealed an order for Coreg 3.125 mg by mouth twice daily with meals at 8:00 AM and 5:00 PM. Observation of a medication pass, on 04/23/14 at 9:40 AM, revealed Licensed Practical Nurse (LPN) #1 administered Coreg (blood pressure) 3.125 milligrams (mg), one (1) tablet by mouth at 9:40 AM to Resident B. The resident was not eating a meal at the time of administration. Interview with LPN #1, on 04/23/14 at 9:50 AM, revealed Resident B had breakfast at approximately 8:00 AM. She revealed medications should be administered one hour before or after the scheduled time. Interview with the Pharmacist, on 04/24/14 at 1:15 PM, revealed If Coreg was ordered for hypertension, it was recommended to administer the medication with food to decrease the chances of orthostatic effects. Interview with the Director of Nursing (DON), on 04/24/14 at 2:00 PM, revealed she expected staff to give medications one hour before or after the scheduled time on the MAR. She expected staff to follow the physician's order or get it clarified.	F 281	employ Certified Medication Aides. The Director of Nursing and Pharmacist provided the in-service. All residents are protected as a result of the in-service instruction and weekly monitoring of physician orders by the Director of Nursing and Pharmacist. The monitoring of physician orders and monitoring of blood pressures will be the responsibility of the Director of Nursing and Pharmacist. The monitoring will be accomplished through weekly review of physician orders and blood pressures x 8 weeks to ensure medications are given as ordered and to ensure blood pressures are within normal limits. Monitored by the Director of Nursing and Pharmacist a Quality Assurance an audit on physician orders will be conducted beginning in May 2014 and monthly x 2.	6/3/14	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F 281 continued on separate page F282 It is the policy of NHC Madisonville to provide and arrange services by qualified persons in accordance with each resident's plan of care.		

The findings will be reported to the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab.. The monitoring will be continued by the Director of Nursing and Pharmacist or as directed by the Quality Assurance Committee.

Monitored by the Director of Nursing, a Quality Assurance an audit on blood pressures will be conducted beginning in June 2014 and monthly x 2. The findings will be reported to the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. The monitoring will be continued by the Director of Nursing or as directed by the Quality Assurance Committee.

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F 282	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's "Care Plans" policy and procedure it was determined the facility failed to ensure services provided or arranged by the facility were provided by qualified persons in accordance with the resident's written plan of care for one (1) of seventeen (17) sampled residents (Resident #1). Observations revealed fall mats were not in use as per the resident's care plan. The findings include: Review of the facility's policy and procedure, titled "Care Plans", dated 01/01/05, revealed care plan approaches are specific, individualized steps partners and patients will take to assist the patient to achieve the goal. Record review revealed the facility admitted Resident #1 on 11/11/11 with diagnoses which included Atrial Fibrillation, Hypertension, Gastroesophageal Reflux Disease, Anemia, Dementia, and Cerebral Atherosclerosis. Review of the Comprehensive Care Plan, last revised 03/17/14, revealed an intervention for mats on floor beside the bed. Observations, on 04/21/14 at 8:35 AM and 10:12 AM, revealed Resident #1 was in the bed and there were two floor mats standing against the wall on the left side of resident's bed. Interview with the Team Leader, on 4/24/14 at	F 282	The fall mats were placed at the bedside of Resident # 1 on 04/22/14 upon the instruction of the Director of Nursing to ensure care plan compliance. A visual audit was completed by the DON, ADON, and RN LPN Team Leaders of all residents was completed on 04/22/14. The audit included residents with fall mats. The audit found all fall mats were properly placed therefore no other residents were affected by out of place fall mats. In-service instruction and education was provided to the licensed nursing staff and CNA staff on 04/25/14 on compliance with care plan interventions and fall mat use. The Director of Nursing provided the in-service training. . In addition, in-service instruction and education was provided on 04/25/14 to the housekeeping staff on fall mat interventions. The Director of Nursing provided the in-service training. Understanding of the education by the staff was validated by return demonstration and visual observation of tasks following the training. Further validation in understanding the education is monitoring of results through the QA process.	

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F 282	Continued From page 3 1:34 PM, revealed she expected staff to follow the care plan for fall mats to be placed at the resident's bedside. Interview with the Assistant Director of Nursing (ADON), on 4/22/14 at 2:27 PM, revealed the care plan should be followed and if the resident was in bed, the fall mats should be on the floor by the bed.	F 282	All residents are protected as a result of the in-service and instruction regarding implementation of care plan interventions and fall mat use. F 282 continued on separate page	6/3/14	
F 323 SS=E	483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Material Data Safety Sheets (MSDS), and review of the facility's "Storage of Chemicals" policy/procedure, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible related to the storage of chemicals behind unlocked doors in the facility. The facility identified thirteen (13) residents with behavior of wandering. Additionally, the facility	F 323	F 323 It is the policy of NHC Madisonville to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Coded keyless entry locks were installed by maintenance supervisor on the soiled utility/biohazard room located on B Hall, the Central Supply room, all soiled utility rooms, and on all storage room doors containing hazardous chemicals. The maintenance director installed the coded keyless entry locks on 05/08/14. A 100% review of all residents was completed on 04/28/14 by DON, ADON, and RN LPN Team Leaders, including the thirteen residents with behaviors, with all residents being at their baseline condition. Therefore no residents were affected by hazardous chemicals.		

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Continuation of F 282

The monitoring of care plan interventions and fall mat use will be the responsibility of the Director of Nursing. The monitoring will be accomplished through visual daily monitoring of care plan interventions and falls mat use by the DON, ADON, RN LPN Team Leaders and Nurse Supervisors. The monitoring will be weekly x 8 weeks.

Monitored by the Director of Nursing a Quality Assurance audit will be conducted beginning in May 2014 and monthly x 2. The findings will be reported to the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. The monitoring will be continued by the Director of Nursing or as directed by the Quality Assurance Committee.

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F 323	<p>Continued From page 4</p> <p>failed to ensure each resident received adequate assistance devices to prevent injuries with falls for one (1) of seventeen (17) sampled residents (Resident #1). Resident #1 did not have fall mats in place on the floor by the bed to prevent potential injury.</p> <p>The findings include:</p> <p>Review of the facility's "Storage of Chemicals" policy/procedure, (not dated), revealed each chemical would be utilized for it's intended use and stored under lock and key as recommended.</p> <p>Observation of the soiled utility/biohazard room located on (B) hall, on 04/22/14 at 12:00 PM and on 04/23/14 at 9:00 AM and 2:05 PM, revealed the room was accessible as the key was left in the door lock. The following was observed in the room:</p> <ol style="list-style-type: none"> (1) container of all purpose liquid odor neutralizer (1) container of heavy duty floor cleaner <p>Review of the MSDS for "Water Soluble Deodorant", dated 09/28/12, revealed the product may cause mild skin irritation and was an eye irritant.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/22/14 at 12:20 PM, revealed the soiled utility room key should be placed above the door after leaving the room; however, staff "sometimes forget" and leave the key in the door.</p> <p>Observation of the Central Supply room on the Round Station, on 04/23/14 at 2:05 PM, revealed the room was accessible as the key was left in the door lock. The following was observed in the</p>	F 323	<p>The installation of coded keyless entry locks protects all residents from the storage of hazardous chemicals.</p> <p>In-service instruction and education was provided to the licensed nursing staff, CNA staff, dietary staff, and housekeeping staff on 05/06/14 on storage of hazardous chemicals and coded keyless entry door locks. The Administrator provided the in-service training.</p> <p>Understanding of the education by the staff was validated by return demonstration and visual observation of tasks following the training. Further validation in understanding the education is monitoring of results through the QA process.</p> <p>The monitoring of storage hazardous chemicals and keyless entry door locks will be the responsibility of the Maintenance Director. The monitoring will be accomplished through daily inspection of the coded keyless entry door locks.</p> <p>Monitored by the Maintenance Director a Quality Assurance audit will be conducted beginning in May 2014 and monthly x 2. The findings will be reported to the Quality Assurance Committee which consists of the administrator, DON, medical director,</p>		

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F 323	<p>Continued From page 5 room:</p> <p>1. (1) spray bottle of general virucide, bactericide, tuberculocide, fungicide, sanitizer 2. (1) bottle Isopropyl rubbing alcohol</p> <p>Review of the MSDS for "Isopropyl Alcohol", (not dated), revealed inhalation of vapors would irritate the respiratory tract. Ingestion could cause drowsiness, unconsciousness, and death. It could also cause skin irritation and eye irritation.</p> <p>Interview with the Director of Nursing (DON), on 04/24/14 at 2:00 PM, revealed staff should retrieve the key from the hook above the door and put the key back when leaving the room. She revealed staff should never leave the door accessible to residents.</p> <p>Interview with the Administrator, on 04/24/14 at 2:15 PM, revealed staff should never leave the key in the door to the soiled utility room or the central supply room. He revealed the doors should be locked at all times and the key inaccessible to residents.</p> <p>2. Record review revealed the facility admitted Resident #1 on 11/11/11 with diagnoses which included Atrial Fibrillation, Hypertension, Gastroesophageal Reflux Disease, Anemia, Dementia, and Cerebral Atherosclerosis. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 02/27/14, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of twelve (12) indicating the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan, last</p>	F 323	<p>associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.</p> <p>The fall mats were placed at the bedside of Resident # 1 on 04/22/14 upon the instruction of the Director of Nursing to ensure safety for the resident.</p> <p>A visual audit of 100% of all residents was completed by DON, ADON and RN LPN Team Leaders on 04/22/14. The audit included residents with fall mats. The audit found all fall mats were properly placed therefore no other residents were affected by out of place fall mats.</p> <p>In-service instruction and education was provided to the licensed nursing staff, CNA staff, and housekeeping staff on 04/25/14 on compliance of fall mat use. The Director of Nursing provided the in-service training.</p> <p>Understanding of the education by the staff was validated by return demonstration and visual observation of tasks following the training. Further validation in understanding the</p>		

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F 323	Continued From page 6 revised 03/17/14, revealed an intervention for mats on the floor beside bed. Observations, made on 04/21/14 at 6:35 AM and 10:12 AM, revealed Resident #1 was in the bed and there were two (2) floor mats standing against the fall on the left side of resident's bed. Interview on 4/24/14 at 1:34 PM with the Team Leader revealed she expected staff to have the fall mats on the floor by the bed to help reduce the risk of injury in the event Resident #1 fell from the bed. Interview on 4/22/14 at 2:27 PM with Assistant Director of Nursing (ADON) revealed if the resident was in the bed, the fall mats should be on the floor bedside the bed to decrease the risk for injury if Resident #1 rolled out of the bed. Interview on 4/22/14 at 2:35 PM with Director of Nursing (DON) revealed, she expects the staff to follow the care plan and that fall mats are placed at resident's bedside to minimize the risk of injury in the event of a fall from the bed.	F 323	education is monitoring of results through the QA process. All residents are protected as a result of the in-service and instructions regarding fall mat use. The monitoring of fall mat use will be accomplished through daily review of fall mat use during rounds by DON, ADON, RN LPN Team Leaders and nursing supervisors. Monitored by the Director of Nursing, a Quality Assurance audit will be conducted beginning in May 2014 and monthly x 2. The findings will be reported to the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. Monitoring will be continued by the Director of Nursing as directed by the Quality Assurance Committee.	6/3/14	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 It is the policy of NHC Madisonville to procure food from sources approved or considered satisfactory by Federal, State, or Local authorities; and store,		

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F 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's "Refrigerated Food Storage Guide" policy, it was determined the facility failed to ensure food was stored under sanitary conditions. Review of the Census and Condition, dated 04/22/14, revealed there were eighty-two (82) residents with five (5) residents receiving tube feeding. The findings include: Review of the "Refrigerated Food Storage Guide" policy, (not dated), revealed cottage cheese could be stored until the manufacturer's expiration date or seven (7) days after opening, whichever came first. Milk storage time was the manufacturer's expiration date. Observation, on 04/22/14 6:15 AM, revealed the following in the refrigerator: 1. (1) unopened container of cottage cheese with a "best by" date of 04/07/14. 2. (1) opened container of cottage cheese, dated as opened 04/16/14 with a "best by" date of 04/07/14. 3. (1) opened container of fat free skim milk with a manufacturer's date of 04/19/14. Interview with the Dietary Manager, on 04/22/14 at 6:50 AM, revealed the milk should have been discarded after the expiration date listed on the container and the cottage cheese should have been discarded by the manufacturer's expiration date or seven (7) days after opening, whichever came first.	F 371	prepare, distribute and serve food under sanitary conditions. Monitored by the Dietary Manager, the unopened container of cottage cheese with a 'best buy' date of 04/07/14 was removed and discarded from the refrigerator on 04/22/14. The opened container of cottage cheese with a 'best buy' date 04/16/14 was removed and discarded from the refrigerator on 04/22/14. The opened carton of fat free skim milk with a manufacturer's date of 04/19/14 was removed and discarded from the refrigerator on 04/22/14. The removal and discarding of products with out of date 'best buy' dates protects all residents. Monitored by the Dietary Manager on 04/22/14 a visual inspection was completed on all refrigerated products with no other findings of out of compliance 'best buy' dates. The dietary manager conducted in-service training and education for all dietary staff members on 04/25/14 related to 'best buy' dates. The monitoring of 'best buy' dates will be the responsibility of the Dietary Manager. The monitoring will be accomplished through daily inspection	

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F 371	Continued From page 8	F 371	of 'best buy' dates through visual inspection of food products.	6/3/14	
F 441 SS=E	483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	F 371 Continued on separate page F 441 It is the policy of NHC Madisonville to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. On 04/22/14 CNA's were provided in-service education and training by Team Leaders on hand washing and the use of hand sanitizer during meal tray pass. By providing in-service education and training to CNA on hand washing and use of hand sanitizer protects all residents related to infection control issues. In-service instruction and education was provided to the licensed nursing staff and CNA staff on 04/28/14 and 04/30/14 regarding hand washing and use of hand sanitizer during meal tray pass. The Director of Nursing provided the in-service.		

NHC Madisonville Page 9a

Continuation of F 371

Monitored by the Dietary Manager a Quality Assurance audit will be conducted beginning in May 2014 and monthly x 2. The findings will be reported to the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. The monitoring will be continued by the dietary Manager as directed by the Quality Assurance Committee.

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F 441	<p>Continued From page 9</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility's "Infection Control Manual, Handwashing" policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for ten (10) of ten (10) unsampled residents related to staff failing to sanitize their hands during meal pass.</p> <p>The findings include:</p> <p>Review of the facility's "Infection Control Manual, Handwashing" Policy, last revised 10/01/08, revealed handwashing is performed to decrease the number of microorganisms, preventing cross contamination between staff and patients.</p> <p>Observation during a meal pass on Hall "C", on 04/22/14 at 10:01 PM, revealed three (3) staff passing food trays to ten (10) unsampled residents without sanitizing hands.</p> <p>Interviews with Certified Nurse Aide (CNA) #1, CNA #2 and CNA #3, on 04/22/14 at 12:30 PM and 12:35 PM and on 04/23/14 at 12:33 PM, revealed staff should use hand sanitizer between tray pass of each resident and should wash their hands with soap and water after every third resident. The CNAs stated they did not use hand</p>	F 441	<p>The monitoring of the hand washing and use of hand sanitizer will be the responsibility of the Director of Nursing. The monitoring will be accomplished through daily visual observation of hand washing and hand sanitizer use during meal tray pass. The monitoring will be weekly x 8 weeks.</p> <p>Monitored by the Director of Nursing a Quality Assurance audit will be conducted on hand washing and hand sanitizer use beginning in May 2014 and monthly x 2. The findings will be reported to the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. The monitoring will be continued by the Director of Nursing as directed by the Quality Assurance Committee.</p>	6/3/14

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F 441	Continued From page 10 sanitizer or wash hands during the meal pass for lunch on 04/22/14. Interview with Registered Nurse (RN) #1, on 04/22/14 at 12:50 PM, revealed she expected staff to sanitize hands between every meal tray pass and wash their hands after every third resident. The RN stated this was to prevent the spread of infection from resident to resident. Interview with Team Leader #1 and #2, on 04/22/14 at 1:00 PM and 1:04 PM, revealed staff should wash their hands using hand sanitizer during meal pass for up to three (3) residents. They stated before passing additional food trays or after resident care, staff should wash their hands using soap and water to prevent the spread of infection from resident to resident. The Team Leaders revealed there were no exceptions to this practice based on staff job description. Interview with the Director of Nursing, on 04/24/14 at 2: 37 PM, revealed she expected all staff to wash their hands between each resident during meal pass. She stated if staff provide care such as pulling up residents in bed or their hands become soiled during the meal pass, the staff should wash hands with soap and water before continuing to pass meal trays. She revealed the concern with staff not washing and sanitizing their hands was the spread of infection.	F 441			
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502	F 502 It is the policy of NHC Madisonville to provide and obtain laboratory services to meet the need of residents.		

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F 502	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a Basic Metabolic Profile (BMP) was obtained timely for one (1) of seventeen (17) sampled residents (Resident #13). The staff failed to obtain a BMP for Resident #13 on 04/04/14 per physician's order.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #13 on 03/25/14 with diagnoses which included Compression of Brain, Cerebral Aneurysm, Wound Dehiscence, Urinary Obstruction with retention, Hypertension, Hyperlipidemia, Insomnia, and Tracheostomy.</p> <p>Review of the physician orders, dated 04/01/14, revealed an order for a BMP to be obtained on 04/04/14 (Friday) with morning labs.</p> <p>Review of Resident #13's laboratory reports, revealed there was no laboratory report for a BMP drawn on 04/04/14.</p> <p>Interview with the Team Leader (TL), on 04/23/14 at 1:34 PM, revealed the BMP was placed on the calender at the nursing station and should have been drawn but it was not obtained. She stated lab services draws the labs on Tuesday's but on other days it is the responsibility of the 11 PM to 7 AM nurse to draw the labs ordered. She indicated that labs were tracked by the Team Leader Monday through Friday but no one tracks them on the weekends.</p>	F 502	<p>The physician was contacted on 04/22/14 by nurse supervisor and a BMP lab test for Resident # 13 was obtained on 04/22/14. The physician was contacted upon the instruction of the Director of Nursing.</p> <p>A 100% audit of pending labs due was competed by DON, ADON and RN LPN Team Leaders on 04/25/14 on all residents. All other labs are on track to be done according to the time frame due. There were no other labs that were 'missed' on residents.</p> <p>In-service instruction and education was provided to the licensed nursing staff on 04/28/14 and 04/30/14 regarding pending labs due. The Director of Nursing provided the in-service.</p> <p>All residents are protected as a result of the in-service and instruction regarding pending labs.</p> <p>The monitoring of pending labs will be the responsibility of the Director of Nursing. The monitoring will be accomplished through weekly monitoring of pending lab work schedules. The day shift RN will be in charge of monitoring labs on weekends.</p> <p>Monitored by the Director of Nursing a Quality Assurance a monitor of 10 labs per week x 8 weeks will be conducted on pending lab work to ensure</p>	

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F 502	Continued From page 12 Interview with Licensed Practical Nurse (LPN) #2, on 04/24/14 at 12:45 PM, revealed the an order from the physician should be placed in the computer which generates three (3) copies. She further revealed one copy is placed on the chart, one is placed in the basket at the nurses station for the physician to sign and one should be placed in the Team Leader's office for tracking. She stated the BMP ordered for 04/04/14 should have been drawn by the night nurse. Interview with the Assistant Director of Nursing (ADON), on 04/24/14 at 2:27 PM, revealed she was not notified the BMP was never collected. She stated she would expect the night nurse to draw the lab as ordered by the physician. She revealed the orders are placed in the computer, placed on the Treatment Administration Record (TAR), and communicated via the calendar at the nurses station. She stated the Team Leader checks labs daily Monday through Friday. She revealed she expected the nurse on the weekend to follow-up on any labs pending. Interview with the Director of Nursing (DON), on 04/24/14 at 2:35 PM, revealed all orders were reviewed daily Monday through Friday by the TL, ADON and DON. The DON revealed she expected all labs ordered to be obtained in a timely manner or on the specific date of the order. She revealed she was not aware the BMP was not obtained on 04/04/14 as ordered by the physician.	F 502	compliance with physician orders beginning in May 2014. The findings will be reported to the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. The monitoring will be continued by the Director of Nursing as directed by the Quality Assurance Committee.	6/3/14	

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1965.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1965, and upgraded in 1995 with 128 smoke detectors and 10 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965 and upgraded in 2012.</p> <p>GENERATOR: Type II generator installed in 1972. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code Survey was conducted on 04/23/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety-four (94) beds with a census of eighty-two (82) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>K 052</p> <p>It is the policy of NHC Madisonville to install, test, and maintain the fire alarm system in accordance with NFPA standards.</p> <p>On 04/23/14 the fire alarm inspector vendor was contacted by the Maintenance Director. The Maintenance Director educated the fire alarm inspector vendor to perform a charger test and discharge test on the fire alarm system batteries on an annual basis. In addition, the fire alarm inspector vendor was contacted and educated to perform a voltage load test on the fire alarm system batteries on a semi-annual basis.</p> <p>A 100% audit of remaining fire alarm system review was completed by the Maintenance Director on 04/25/14 and all other checks were made.</p> <p>The maintenance director conducted in-service education and instruction on 04/25/14 with the fire alarm inspector vendor to ensure the charge test on the fire alarm system batteries and discharge test on the fire alarm system batteries was completed on an annual</p>	



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

Arny Belman

TITLE

Adm

(X6) DATE

6-24-14

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 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 052 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFWA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on fire alarm inspections and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for ninety-four (94) beds and at the time of the survey, the census was eighty-two (82). The findings include:	K 052	<p>basis and the voltage load test being done on a semi-annual basis. On 04/25/14 the administrator conducted in-service education for the Maintenance Director to ensure the charge test on the fire alarm system batteries and discharge test on the fire alarm system batteries was completed by the fire alarm vendor on an annual basis and the voltage load test being done on a semi-annual basis.</p> <p>All residents, staff, and visitors are protected by the in-service education and instruction regarding the fire alarm system tests and documentation.</p> <p>The monitoring of the charger test, discharge test, and voltage load test of the batteries on the fire alarm system will be the responsibility of the Maintenance Director. The monitoring will be accomplished through inspection of documentation of the fire alarm system from the inspection vendor.</p> <p>Overseen and monitored by the Maintenance Director a Quality Assurance audit of the center's compliance with charger test, discharge test, and voltage load test of the batteries on the fire alarm system will be conducted monthly x 2 beginning in May 2014. The findings will be reported to the Quality Assurance committee which consists of the</p>	

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K 052	Continued From page 2 Fire alarm inspection review, on 04/23/14 at 10:30 AM with the Maintenance Supervisor, revealed the charger test was not documented on the fire alarm inspection paperwork. Interview, on 04/23/14 at 10:31 AM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a charger test on the fire alarm batteries on an annual basis. Fire alarm inspection review, on 04/23/14 at 10:32 AM with the Maintenance Supervisor, revealed the discharge test was not documented on the fire alarm inspection paperwork. Interview, on 04/23/14 at 10:33 AM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a discharge test on the fire alarm batteries on an annual basis. Fire alarm inspection review, on 04/23/14 at 10:34 AM with the Maintenance Supervisor, revealed the load voltage test was not documented on the fire alarm inspection paperwork. Interview, on 04/23/14 at 10:35 AM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a load voltage test on the fire alarm batteries on a semi-annual basis. The census of eighty-two (82) was verified by the Administrator on 04/23/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit	K 052	administrator, DON, medical director, associate medical director, registered dietitian, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab.. The monitoring and training will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.	6/3/14

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K 052	Continued From page 3 Interview on 04/23/14.	K 052		
K 066 SS=E	<p>Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by:</p>	K 066	<p>K 066</p> <p>It is the policy of NHC Madisonville to adopt and maintain smoking regulations according to NFPA standards.</p> <p>On 05-06-14 and 05-07-14 in-service education was provided to all staff related to the designated smoking area of the facility and the proper disposal of cigarette butts. The in-service was conducted by the Administrator, Director of Nursing, and Maintenance Director.</p> <p>On 05-12-14 two (2) approved ashtrays were put in place in the designated smoking area for use.</p> <p>The Maintenance Director received instruction and education from the administrator regarding approved ashtrays in the designated smoking area on 04-25-14.</p> <p>As a result of the in-service on smoking only in the designated area and the use of approved ashtrays in the designated smoking area, the safety of residents, staff, and visitors are protected.</p>	

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K 066	<p>Continued From page 4</p> <p>Based on observation, smoking policy review, and interview, it was determined the facility failed to ensure the use of approved smoking areas, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of five (5) smoke compartments, forty-eight (48) residents, staff and visitors. The facility has the capacity for ninety-four (94) beds and at the time of the survey, the census was eighty-two (82).</p> <p>The findings include:</p> <p>Observation, on 04/23/14 at 12:45 PM with the Maintenance Supervisor, revealed the area at the a-hall exit was being used as a smoking area with fifteen (15) cigarette butts on the ground around the concrete platform.</p> <p>Interview, on 04/23/14 at 12:46 PM with the Maintenance Supervisor, revealed he was unaware of smoking occurring at the exit.</p> <p>Observation, on 04/23/14 at 1:00 PM with the Maintenance Supervisor, revealed the employee smoking shack area had three (3) unapproved ashtrays in use and over twenty-five (25) cigarette butts on the ground.</p> <p>Interview, on 04/23/14 at 1:00 PM with the Maintenance Supervisor, revealed he was unaware the ashtrays at the smoke shack were not the proper type and was unaware of the butts on the ground..</p> <p>The census of eighty-two (82) was verified by the Administrator on 04/23/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit</p>	K 066	<p>The monitoring of the designated area smoking and the use of approved ashtrays in the smoking area will be the responsibility of the Maintenance Director. The monitoring will be accomplished through daily inspection of the designated smoking area and visual inspection of approved ashtrays in the designated smoking area.</p> <p>Overseen and monitored by the Maintenance Director a Quality Assurance audit of the center's compliance of the designated smoking area and approved ashtrays will be conducted monthly x 2 beginning in May 2014. The findings will be reported to the Quality Assurance committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.</p>	6/3/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186016	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2014
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 066	Continued From page 5 Interview on 04/23/14. Actual NFPA Standard: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2014
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 418 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)	(X6) COMPLETION DATE
K 144 K 144 SS=F	Continued From page 6 NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with National Fire Safety Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for ninety-four (94) beds and at the time of the survey, the census was eighty-two (82). The findings include: Generator run log review, on 04/23/14 at 10:17 AM with the Maintenance Supervisor, revealed the transfer time for the generator was not being documented at the facility. Interview, on 04/23/14 at 10:18 AM with the Maintenance Supervisor, revealed he was unaware of the requirement to document the transfer time on his monthly load test paperwork. Further interview revealed he knew it transferred	K 144 K 144	K 144 It is the policy of NHC Madisonville to ensure the emergency generator is maintained in accordance with NFPA standards. In-service instructions and education was given to the Maintenance Director on April 29, 2014 related to performing a power transfer test on the emergency generator. The emergency generator service vendor presented the instructions to the Maintenance Director. The administrator gave instructions on the monthly documentation for the emergency generator log. As a result of performing power transfer time tests on the emergency generator and documentation of the time, the safety of residents, staff, and visitors are protected. The Maintenance Director will monitor the emergency generator transfer test times through visual inspection of the emergency generator test logs on a monthly basis. Overseen and monitored by the Maintenance Director, a Quality Assurance audit of the center's compliance with power transfer test times for the emergency generator and	

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K 144	Continued From page 7 very rapidly but was unaware of the exact seconds. The census of eighty-two (82) was verified by the Administrator on 04/23/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/23/14 Actual NFPA Standard: Reference: NFPA 101 (2000 ed.) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted.	K 144	documentation of the times on the log will be conducted monthly x 2 beginning in May 2014. The findings will be reported to the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. The monitoring will be continued by the Maintenance Director or as directed by the Quality Assurance Committee.	6/3/14