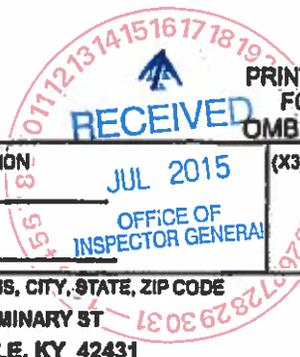


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2015  
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  06/25/2015
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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 SS=D	<p>A Recertification Survey was conducted on 06/23/15 through 06/25/15 with deficiencies cited at the highest Scope and Severity of a "D".</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 interview, record review, and facility policy review it was determined the facility failed to ensure services provided or arranged by the facility met professional standard of quality for one (1) of eighteen (18) sampled residents (Resident #13) related to not developing an interim care plan to address the needs of a hospice resident.</p> <p>The findings include: Review of the Policy and Procedure, "Admitting a Patient", undated, revealed to "initiate Interim Plan of Care". Review of "This Nursing Facility Services Agreement" between the facility and Hospice, dated 09/14/11, revealed the Hospice and Facility will jointly develop and agree upon a coordinated Plan of Care which is consistent with the Hospice philosophy and is responsive to the unique needs of the Hospice Patient and his or her expressed desire for Hospice care. The Plan of Care will identify which provider is responsible for performing the respective functions that have</p>	F 281	<p>F 281</p> <p>NHC Madisonville ensures services provided or arranged by the facility meet professional standards of quality.</p> <p>On 06/26/15 a Hospice RN met with the DON and facility Team Leader to jointly develop a coordinated Plan of Care consistent with Hospice philosophy and responsive to the needs of Resident # 13. The meeting resulted in a collaborative plan of care being developed specifying what the facility and Hospice was responsible for in delivering the respective services to Resident # 13 and at what intervals.</p> <p>On 06/28/15 the family of Resident # 13 revoked the Hospice arrangement between Hospice and facility.</p> <p>On 07/13/15 a 100% visual audit of Hospice resident care plans was reviewed for collaborative care plans involving Hospice and facility to ensure collaboration of services between facility and Hospice. No other residents were found to be affected.</p> <p>On 07/13/15 and 07/14/15 in-service was conducted by the Director of Nursing on collaborative services and responsibility of services between facility and Hospice. The in-service was given to 100% of the licensed nursing staff involved in the admissions</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danny Belcher TITLE: adm (X8) DATE: 7-16-15

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 410 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	
F 281	Continued From page 1 been agreed upon and included in the Plan of Care.  Record review revealed the facility admitted Resident #13 to the facility on 06/19/15, with diagnosis which include Congestive Heart Failure (CHF) and Alzheimer's Disease. Review of the Admission Physician Orders, dated 06/19/15, revealed "Hospice services to treat".  Review of Resident #13's Interim Care Plan, dated 06/19/15, there was a plan of care developed for "End of Life" care; however, the plan of care did not address the coordination of care with the hospice agency and staff.  Interview with Licensed Practical Nurse (LPN) #1, on 06/25/15 at 5:10 PM, revealed there was not a Plan of Care (POC) sent from Hospice that defined the role Hospice would play in the care of the resident. LPN #1 stated she only received the orders for the medications the resident would be taking and the accepting physician ordered those medications per Hospice instruction.  Interview with the Director of Nursing (DON), on 06/25/15 at 5:08 PM, revealed there was not a collaborative plan of care developed with Hospice to define the role of the facility and Hospice for the care of the resident.  Interview with the Administrator, on 06/25/15 at 5:34 PM, revealed he expected Hospice to provide a POC to the facility and work with the facility to coordinate the services Hospice would be providing to the resident.	F 281	process, ADON, MDS coordinators, RN/LPN Team Leaders and social work staff.  Monitoring of collaborative care plans and responsibility of services between facility and Hospice is the responsibility of the Director of Nursing, RN/LPN Team Leader staff and MDS coordinators. Monitoring will occur through admission visual audit and weekly visual audit of Hospice and facility collaborative Plans of Care.  All Quality Assurance Monitors will be reported to the Center's Quality Assurance Committee consisting of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director, and HIM Director monthly. In-service training and Quality Assurance Monitors will continue as directed by the Quality Assurance Committee and the Regional Nurse.	7/24/15	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	<p>Continued From page 2</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review it was determined the facility failed to communicate, establish, and agree upon a coordinated Plan of Care (POC) for the facility and Hospice Services which reflects the hospice philosophy, and was based on an assessment of the individual's needs and unique living situation in the facility for one (1) of two (2) residents who received Hospice services in the selected sample of eighteen (18) residents.</p> <p>The findings include:</p> <p>Review of "This Nursing Facility Services Agreement" between the facility and Hospice, dated 09/14/11, revealed the Hospice and Facility will jointly develop and agree upon a coordinated Plan of Care which is consistent with the Hospice philosophy and is responsive to the unique needs of the Hospice Patient and his or her expressed desire for Hospice care. The Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care.</p>	F 309	<p>F309</p> <p>NHC Madisonville ensures each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>On 06/26/15 a Hospice RN met with the DON and facility Team Leader to jointly develop a coordinated Plan of Care consistent with Hospice philosophy and responsive to the needs of Resident # 13. The meeting resulted in a collaborative plan of care being developed specifying what the facility and Hospice was responsible for in delivering the respective services to Resident # 13 and at what intervals.</p> <p>On 06/28/15 the family of Resident # 13 revoked the Hospice arrangement between Hospice and facility.</p> <p>On 06/29/15, the facility DON met with the DON of Western Kentucky Hospice to establish expectations for future admissions. The 'OIG audit tool' will be utilized as a guide for ensuring all required documentation is provided and</p>		

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F 309	<p>Continued From page 3</p> <p>Review of the contract provided by the facility titled, "Hospice of Western Kentucky Business Associate Agreement", and signed by the Administrator, on 08/20/13, did not define the roles the Facility and Hospice would maintain in the care of the resident.</p> <p>Record review revealed the facility admitted Resident #13 to the facility on 06/19/15, with diagnosis to include Congestive Heart Failure (CHF) and Alzheimer's disease. Review of the Admission Physician's Orders, dated 06/19/15, revealed the physician ordered "Hospice services to treat". Further review of the record revealed there was no certificate to show the reason for Hospice.</p> <p>Review of the Interim Care Plan, dated 06/19/15, revealed there was no Plan of Care (POC) related to the coordination of the care provided by hospice and facility. In addition, review of the Nursing Notes since admission, revealed there was no documentation to indicate what services had been provided to Resident #13 in the facility by Hospice.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/25/15 at 5:10 PM, revealed there was not a Plan of Care (POC) sent from hospice that defined the role Hospice would play in the care of the resident.</p> <p>Interview with the Director of Nursing (DON), on 06/25/15 at 5:08 PM, revealed there was not a collaborative plan of care developed with Hospice to define the role of the facility and Hospice for the care of the resident.</p> <p>Interview with the Administrator, on 06/25/15 at</p>	F 309	<p>received before hospice residents are admitted to the facility to include plan of care. The audit tool includes election requirements, plan of care requirements, services requirements, certification of terminal illness requirements, and medication requirements.</p> <p>On 07/14/15 the administrator conducted a 100% audit of all Hospice contracts and all were found to be compliant.</p> <p>On 07/13/15 a 100% visual audit of Hospice resident care plans was reviewed for collaborative care plans involving Hospice and facility to ensure collaboration of services between facility and Hospice. No other residents were found to be affected.</p> <p>On 07/13/15 and 07/14/15 the facility DON educated 100% of staff involved in the admission process to include the Social Service Director, RN/LPN Team Leaders, RN MDS Coordinators, and the business office manager regarding the 'OIG audit tool' for all Hospice admissions to ensure collaboration in accordance with regulation. The Hospice Director also provide the same in-service to the hospice staff to ensure education efforts were collaborated.</p> <p>Monitoring of collaborative care plans and responsibility of services between facility and Hospice is the responsibility</p>		

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F 309	Continued From page 4 5:34 PM, revealed he expected the Hospice to provide a POC to the facility and work with the facility to coordinate the services Hospice would be providing to the resident.	F 309	of the Director of Nursing, RN/LPN Team Leader staff and MDS coordinators. Monitoring will occur through admission visual audit and weekly visual audit of Hospice and facility collaborative Plans of Care.  All Quality Assurance Monitors will be reported to the Center's Quality Assurance Committee consisting of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director, and HIM Director monthly. In-service training and Quality Assurance Monitors will continue as directed by the Quality Assurance Committee and the Regional Nurse.	7/24/15	

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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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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1985.</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 1985 and upgraded in 2012.</p> <p>GENERATOR: Type II generator installed in 1972. Fuel source is Natural Gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 06/24/14. 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-eight (88) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danny Belcher TITLE: adm (X5) DATE: 7-16-15

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 029 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b> One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, two (2) 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-eight (88).  The findings include:  Observation, on 06/24/15 at 11:28 AM, with the	K 029	K 029  NHC Madisonville ensures the facility meets the requirements for Protection of Hazards in accordance with NFPA standards.  On 07/10/15 the collection of hazardous materials, including shoes and pictures, was removed from Resident Room 212.  A 100% audit of remaining resident rooms was completed on 07/13/15 with no other resident rooms found to be affected.  The maintenance director and administrator conducted in-service training and instruction on 07/14/15 regarding the collection of hazardous materials in resident rooms. The in-service training was given to 100% of housekeeping staff, 100% of CNA staff, and 100% of licensed nurse staff.  All residents, staff, and visitors are protected by the in-service education and instruction regarding the removal of hazardous materials.  The monitoring of the collection of hazardous materials in resident rooms will be the responsibility of the	

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K 029	<p>Continued From page 2</p> <p>Maintenance Director revealed hazardous amounts of personal belongings such as pictures and multiple pairs of house shoes were being stored in Resident Room #212.</p> <p>Interview, on 06/24/15 at 11:29 AM, with the Maintenance Director revealed he was aware of the storage in the room; however, not aware of the requirements for protection from hazards.</p> <p>The census of eighty-eight (88) was verified by the Administrator on 06/24/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/24/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>) (3) Paint shops</p>	K 029	<p>Maintenance Director and Housekeeping Supervisor. The monitoring of hazardous materials in resident room will be accomplished through visual inspection and audit of resident rooms on a weekly basis.</p> <p>Overseen and monitored by the Maintenance Director a Quality Assurance audit of the center's compliance with the collection of hazardous materials in resident rooms will be conducted monthly x 2 beginning in July 2015. The findings will be reported to the Center's Quality Assurance Committee consisting of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping &amp; Laundry Director, and HIM Director monthly. In-service training and Quality Assurance Monitors will continue as directed by the Quality Assurance Committee.</p>	7/24/15

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K 029	<p>Continued From page 3</p> <p>(4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the</p>	K 029		

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K 029	Continued From page 4 door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, fuel fired HVAC, and water heater rooms were installed in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twelve (12) 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-eight (88).  The findings include:	K 068	K 068  NHC Madisonville ensures combustion air and ventilation for boilers, incinerators, fuel fired HVAC, and water heat rooms are installed according to NFPA standards.  On 07-23-15 an electric water heater is scheduled to be installed to replace the fuel fired water heater.  The Maintenance Director received instruction and education from the administrator regarding the need for the electric water heater on 07/15/15.  As a result of the in-service and installation of the electric water heater, the safety of residents, staff, and visitors are protected.  The monitoring of the electric water heater will be the responsibility of the Maintenance Director. The monitoring will be accomplished through weekly inspection of the electric water heater.	

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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  06/24/2015	
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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K 068	<p>Continued From page 5</p> <p>Observation, on 06/24/15 at 11:10 AM, with the Maintenance Director revealed a gas fired water heater was installed and open to the Kitchen using Kitchen air for combustion. The Kitchen had a roll down type service door installed in an opening to the dining room that was not connected to the fire alarm system. The roll down type door was open and obstructed from closing due to a personal fan sitting on the sill of the opening.</p> <p>Interview, on 06/24/15 at 11:11 AM, with the Maintenance Director revealed he was not aware of the requirements for fuel fired water heaters.</p> <p>The census of eighty-eight (88) was verified by the Administrator on 06/24/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/24/15.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>Section 19.5 Building Services</p> <p>19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that 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</p>	K 068	<p>Overseen and monitored by the Maintenance Director a Quality Assurance audit of the operation of the electric water heater will be conducted monthly x 2 beginning in July 2015. The findings will be reported to the Center's Quality Assurance Committee consisting of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping &amp; Laundry Director, and HIM Director monthly. In-service training and Quality Assurance Monitors will continue as directed by the Quality Assurance Committee.</p>	7/24/15

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K 068	Continued From page 6 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 068		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, two (2) 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-eight (88).  The findings include:  Observation, on 06/24/15 at 10:30 AM, with the	K 076	K 076  NHC Madisonville ensures medical gas storage and administration areas are protected in accordance with NFPA standards.  The 'E' tank stored on the floor was placed in a carrier on 06/24/15 to prevent the tank from falling over. The 'E' tank was removed to the oxygen storage room on 06/24/15 thus removing the tank from ignition sources and combustible items.  In-service instructions and education was given to 100% of licensed nurse staff and 100% of CNA staff on July 14, 2015 related to storage of 'E' tanks. The education was conducted by the Maintenance Director.  As a result of providing education and training on 'E' tank storage, the safety of residents, staff, and visitors are protected.  The Maintenance Director will monitor the storage of 'E' tanks through visual inspection of resident rooms and oxygen room storage areas on a weekly basis.  Overseen and monitored by the Maintenance Director a Quality	

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K 076	<p>Continued From page 7</p> <p>Director of Maintenance revealed an "E" type oxygen cylinder was stored on the floor. The tank was not being stored in a rack to prevent the tank from falling over. Further observation revealed the tank was not in use; however, ignition sources and combustible items were within five (5) feet of the tank.</p> <p>Interview, on 06/24/15 at 10:31 AM, with the Director of Maintenance revealed he was not aware the tank had not been returned to the oxygen storage room.</p> <p>The census of eighty eight (88) was verified by the Administrator, on 06/24/15. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 06/24/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 8-3.1.11.2 Storage for nonflammable gases less than 85 m<sup>3</sup> (3000 ft<sup>3</sup>) (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. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic</p>	K 078	<p>Assurance audit of the center's compliance with storage of 'E' oxygen tanks in resident rooms will be conducted monthly x 2 beginning in July 2015. The findings will be reported to the Center's Quality Assurance Committee consisting of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping &amp; Laundry Director, and HIM Director monthly. In-service training and Quality Assurance Monitors will continue as directed by the Quality Assurance Committee.</p>	7/24/15

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K 076	<p>Continued From page 8</p> <p>sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(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.</p> <p>(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.</p> <p>(e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.</p> <p>(f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d.</p> <p>(g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13.</p> <p>(h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27.</p> <p>(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.</p> <p>(j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.</p> <p>8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: <b>CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</b></p>	K 076			