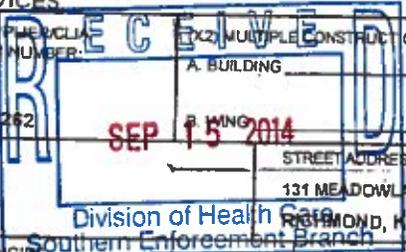


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/05/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	EX2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/21/2014
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of wheelchair cleaning schedules, facility work orders, and the painting schedule, it was determined the facility failed to ensure housekeeping and maintenance services were provided to maintain a comfortable environment for six (6) of twenty-two (22) residents (seventeen sampled residents and five unsampled residents), (Residents #6, A, B, C, D, and E). In addition the facility failed to ensure resident rooms and doorways were in good repair for five (5) of fifty-three (53) resident rooms. Observations revealed dust and dirt buildup on wheelchairs for Residents #6, A, B, C, D, and E. Walls were observed scarred/gouged in resident rooms 14, 17, and 43. Strike plates were observed loose on resident room doorjamb for rooms 12 and 36. Tiles were missing/broken in the showers on the C, D, and E Wing shower and in the therapy shower on the A and B Wings.</p> <p>The findings include:  An interview conducted with the facility</p>	F 253	F253		
			<ol style="list-style-type: none"> <li>All identified maintenance issues will be corrected by 9/23/2014 by the Maintenance Director. This includes scarred and gouged walls in resident rooms 14, 17, and 43, loose strike plates on resident room doorways for rooms 12 and 36, broken and missing tiles in the C, D, and E wings shower rooms and in the therapy shower on A and B wings. Wheel Chairs for residents #6, A, B, C, D, and E that were identified with dust and dirt build-up were cleaned on 8/21/2014.</li> <li>Administrator to complete a one time audit of every room in center, including shower rooms by 9/22/2014 to identify any scarred and gouged walls in resident's rooms, any loose strike plates on resident room doorways, and any broken and missing tiles in the shower rooms. Any issues identified will have a work order completed and fixed per policy no later than 9/23/2014, unless ordering is required and then it will be fixed upon arrival of piece/part. Unit Managers to complete a one time audit of every wheel chair by 9/08/2014 to ensure that all wheel chairs have been cleaned and are free of dust and dirt build-up.</li> </ol>		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ray Barber TITLE: Administrator (X6) DATE: 9/15/14

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  MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	<p>Continued From page 1</p> <p>Administrator on 08/21/14 at 11:35 AM revealed the facility did not have a written maintenance policy but used the TELS Maintenance System (a computerized system for scheduled maintenance checks) to identify items in need of repair.</p> <p>Observations during the initial tour of the facility conducted on 08/19/14 at 9:40 AM, revealed walls were scarred and gouged in resident rooms 14, 17, and 43. In addition, strike plates were observed loose on resident room doorways for rooms 12 and 36.</p> <p>Observations conducted on 08/19/14 at 11:00 AM of the wheelchair utilized by Resident #6 revealed the wheelchair was soiled with a buildup of dust/dirt on support bars under the seat and the spokes of the wheels.</p> <p>Observations on 08/21/14 at 1:25 PM of wheelchairs used for unsampled residents A, B, C, D, and E revealed the wheelchairs had a buildup of dust and dirt on support bars under the seat and the spokes of the wheels.</p> <p>Observations during an environmental tour on 08/21/14 at 1:50 PM with the Maintenance Director revealed tiles were broken and missing in the C, D, and E Wing shower rooms and in the therapy shower on the A and B Wings.</p> <p>An interview conducted with the Unit Manager of the C, D, and E Wings on 08/21/14 at 1:10 PM revealed staff cleaned the wheelchairs on the third shift and they were checked by the Unit Managers daily to ensure the wheelchairs were clean. Further interview revealed the Unit Manager had not noticed the dust/dirt buildup on the support bars and on the wheel spokes.</p>	F 253	<ol style="list-style-type: none"> <li>Administrator and Maintenance Director to complete a weekly walk through/audit of all rooms and showers rooms x 4 weeks to ensure any scarred and gouged walls, loose strike plates, and broken and missing tiles have been identified and fixed beginning 9/24/2014. Unit Managers to complete a weekly audit of All wheel chairs to ensure they are being cleaned per cleaning schedule. Education Training Director to re-educate staff by 9/22/2014 regarding the wheel chair cleaning schedule, how to complete a work order, when to complete a work order, and to report any maintenance/housekeeping issues to the Administrator/DON/Maintenance Director per work order policy.</li> <li>QA team (consisting of at least the Medical Director, Administrator, Director of Nursing, ADON, UM, Social Services Director, and Life Enrichment Director) to review all audit findings and make revisions to plan as needed every week x 2 weeks beginning 9/23/2014, then at least Monthly or until issue resolved.</li> <li>Date of compliance 9/24/2014.</li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475
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F 253	<p>Continued From page 2</p> <p>An interview conducted with the A and B Wing Unit Manager on 08/21/14 at 1:25 PM revealed the wheelchairs were scheduled to be cleaned at least weekly by third shift staff or as needed and, according to the Unit Manager, she checked the residents' wheelchairs daily during rounds and had not noticed the buildup of dust/dirt on the support bars or the spokes of the wheels.</p> <p>An interview conducted with the Maintenance Director on 08/21/14 at 2:00 PM revealed the facility had a painting schedule in place to paint rooms and repair walls. The Maintenance Director was not aware of which rooms had been painted and when. Further interview revealed the Maintenance Director was not aware of the broken/missing tiles in the shower rooms on the A and B Wings or on the C, D, and E Wings. According to the Maintenance Director, he made rounds to identify concerns and received computerized and paper work orders of items that were in need of maintenance/repairs.</p> <p>A review of the Facility Wheel Chair Cleaning schedule revealed resident wheelchairs were scheduled for cleaning by the third shift staff at least weekly. According to the schedule, wheelchairs were cleaned once a week.</p> <p>A review of the facility painting schedule dated 08/01/14 revealed resident rooms 14, 17, and 43 were not scheduled to be painted in August 2014, and there were no additional painting schedules provided for review.</p> <p>A review of the facility's computerized work orders and maintenance requests documented on paper revealed facility staff had not identified the</p>	F 253		
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NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475	
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F 253	Continued From page 3 scarred and gouged walls in resident rooms 14, 17, and 43 as in need of repairs and/or painting. The loose strike plates on resident room doors 12 and 36 were not listed on computerized work orders or maintenance requests to be repaired. There was no evidence on facility work orders or maintenance requests for repair of the missing/broken tiles on the A and B Wings or in the shower rooms on the C, D, and E Wings.	F 253		
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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure care was provided in accordance with the resident's written plan of care for one (1) of seventeen (17) sampled residents (Resident #7). Review of the Comprehensive Care Plan for Resident #7 dated 06/14/14, revealed a care plan intervention for the resident to have oxygen as ordered at three (3) liters per minute. However, the facility failed to ensure that oxygen was administered to Resident #7 at the correct liter flow as ordered by the resident's physician.  The findings include:  Review of facility policy titled "Care Plan Policy Statement," undated, revealed an individual care	F 282	F282  1. Resident # 7 physician was made aware of oxygen setting on 8/19/2014 and 8/20/2014 on 8/21/2014 by the Director of Nursing. No new orders noted. Medical Director made aware of Resident # 7 Oxygen setting for the dates of 8/19/2014 and 8/20/2014 on 8/21/2014 by the Director of Nursing, no recommendations received.  2. DON/ADON/UM/ETD completed a one time audit of all residents receiving oxygen on 9/15/2014 to identify if oxygen setting was correct. Any issue identified will be corrected immediately and physician notified after resident assessment. All respiratory care plans will be audited by Interdisciplinary Team Members by 9/22/2014 to identify that all care plans are individualized and correct. Any issue identified will be immediately corrected.	

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F 282	<p>Continued From page 4</p> <p>plan that included measurable objectives and timetables to meet residents' medical, nursing, mental, and psychological needs was developed for each resident. Further policy review revealed any licensed nurse and/or interdisciplinary team member could update the care plan to reflect changes. However, the policy failed to address following the resident's individual care plan.</p> <p>Observation on 08/19/14 at 5:24 PM revealed Resident #7's oxygen was set at 3.5 liters per minute. Observations made on 08/20/14 at 12:53 PM and 1:30 PM revealed the resident's oxygen was set at 2 liters per minute.</p> <p>Review of Resident #7's Face Sheet revealed the facility admitted the resident on 06/13/14, with diagnoses that included Acute and Chronic Respiratory Failure, Chronic Airway Obstruction, Congestive Heart Failure, Hypertension, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of Resident #7's Admission Minimum Data Set (MDS) dated 06/20/14, revealed the facility assessed Resident #7 to have a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. The MDS revealed the resident received oxygen treatment.</p> <p>Review of Resident #7's Comprehensive Plan of Care dated 06/17/14, revealed the resident had potential for alteration in oxygen exchange related to Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Acute and Chronic Respiratory Failure as evidenced by the resident's need for oxygen. The care plan revealed the resident required oxygen at 3 liters per minute as ordered by the resident's physician.</p>	F 282	<p>3. ETD/ADON to re-educate nursing staff regarding care plan development, revision, and following care plans.. UM/ADON to audit at least 5 residents who receive oxygen 3 x weekly x 4 weeks beginning 9/22/2014, then 1 x weekly x 4 weeks or as recommended by QA team. IDT to randomly audit at least 3 resident's care plan weekly x 4 weeks beginning 9/22/2014, then 3 residents care plan monthly x 2 months to ensure care plan meets resident's individual needs and is correct. UM to audit any new order for oxygen to ensure oxygen setting is correct by checking oxygen setting at least 3 x within first 3 days ordered beginning week of 9/22/2014 until QA team considers this issue resolved.</p> <p>4. QA team (consisting of at least the Medical Director, Administrator, Director of Nursing, ADON, UM, Social Services Director, and Life Enrichment Director) to review all audit findings and make revisions to plan as needed every week x 2 weeks beginning 9/23/2014, then at least Monthly or until issue resolved.</p> <p>5. Date of compliance 9/24/2014.</p>		

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F 282	Continued From page 5  Review of Physician's Orders for Resident #7, dated 08/01/14, revealed the physician ordered oxygen to be administered at 3 liters per minute.  Review of Resident #7's Treatment Administration Record (TAR) dated August 2014 revealed the resident required oxygen at 3 liters per minute.  Interview with LPN #3 on 08/20/14 at 2:15 PM revealed she was aware that Resident #7's oxygen was supposed to be set at 3 liters per minute and had failed to readjust it because she hadn't taken the time to "let it register" to her that she needed to change it to the correct liter flow.  Interview with LPN #2/the Unit Manager for the C, D, and E Wings on 08/20/14 at 2:25 PM revealed she conducted room checks every morning to ensure that residents were getting proper care which included checking to ensure correct oxygen liter flow. LPN #2 also stated that nurses were required to check resident oxygen liter flow every shift. Further interview with LPN #2 revealed she was not aware that Resident #7's oxygen had been set at the incorrect liter flow.  Interview with the Director of Nursing (DON) on 08/20/14 at 4:20 PM revealed she completed random audits to ensure that nurses were following the resident care plans. The DON also revealed she did daily rounds to ensure that care plans were being followed. Further interview with the DON revealed care plans were located in the computer system and in residents' medical records and nurses were expected to review care plans at least daily.	F 282			
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328			

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F 328 SS=D	<p>Continued From page 6 <b>NEEDS</b></p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to properly administer oxygen for one (1) of seventeen (17) sampled residents (Resident #7). Resident #7 had a physician order for oxygen at three (3) liters per minute and the facility developed a care plan that stated the resident was required to have oxygen as ordered by the physician. However, the facility failed to ensure that oxygen was administered to Resident #7 at the correct liter flow as ordered by the resident's physician and as required by the resident's plan of care.</p> <p>The findings include:  Review of the facility's policy, "Oxygen Administration," with a revision date of October 2010, revealed that facility staff was required to review and follow physicians' orders for oxygen administration.</p>	F 328	<p>F 328</p> <p>1. Resident # 7 physician and family was made aware that order for oxygen was written for (3) liters per minute via nasal cannula but was set at 3.5 liters per minute on 08/19/2014 at 5:24pm and at 2.0 liters per minute on 8/20/2014 at 12:53pm and 1:30pm. No new orders were obtained. Resident #7 has experienced no change in condition. The Medical Director was also made aware of Resident #7's oxygen not being set correctly.</p> <p>2. A one time audit of all oxygen settings was completed by the Director of Nursing, (DON), Unit Managers, (UM), and the Assistant Director of Nursing, (ADON) on 8/21/2014 to identify any oxygen not on setting as ordered by the physician. No other issues were noted.</p> <p>3. Education Training Director to re-educate all licensed personnel regarding following policy on physicians order with focus on oxygen settings and ensuring that oxygen is set on the correct setting per physician's orders by 9/22/2014. DON/ADON to audit at least five (5) residents who receive Oxygen (2) times a week for four (4) weeks beginning week of 9/22/2014, then three (3) residents one (1) time a week for two (2) weeks to ensure resident's are receiving the correct liters of oxygen per physicians orders.</p>		

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NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475
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F 328	<p>Continued From page 7</p> <p>Review of Resident #7's medical record revealed the facility admitted the resident on 06/13/14, with diagnoses that included Acute and Chronic Respiratory Failure, Chronic Airway Obstruction, Congestive Heart Failure, Hypertension, and Chronic Obstructive Pulmonary Disease. Review of Resident #7's Admission Minimum Data Set (MDS) dated 06/20/14, revealed the resident required oxygen treatment.</p> <p>Review of Resident #7's Comprehensive Plan of Care dated 06/17/14, revealed the resident had the potential for alteration in oxygen exchange, and required oxygen per physician orders.</p> <p>Review of Physician's Orders dated 08/01/14 and the Respiratory Treatment Administration Record (TAR) dated August 2014 for Resident #7 revealed the resident was required to have oxygen at 3 liters per minute.</p> <p>However, observation on 08/19/14 at 5:24 PM revealed Resident #7's oxygen was set at 3.5 liters per minute. Observations made on 08/20/14 at 12:53 PM and 1:30 PM revealed the resident's oxygen was set at 2 liters per minute.</p> <p>Interview with LPN #3 on 08/20/14 at 1:30 PM revealed that nurses were required to check residents' oxygen settings once per shift, but had not checked Resident #7's oxygen for her shift (7:00 AM to 3:00 PM shift). She stated she usually checked oxygen settings closer to the end of her shift. LPN #3 verified that Resident #7's oxygen was set on 2 liters per minute.</p> <p>Interview with SRNA #1 on 08/20/14 at 1:42 PM revealed she had not observed Resident #7 to adjust his/her oxygen flow anytime in the past.</p>	F 328	<p>4. QA team (consisting of at least the Medical Director, Administrator, Director of Nursing, ADON, UM, Social Services Director, and Life Enrichment Director) to review all audit findings and make revisions to plan as needed every week x 2 weeks beginning 9/23/2014, then at least Monthly or until issue resolved.</p> <p>5. Date of compliance 9/24/2014.</p>	
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F 328	Continued From page 8  Interview with SRNA #2 on 08/20/14 at 1:44 PM revealed she had not observed Resident #7 to change the oxygen liter flow at any time in the past. SRNA #2 also stated that SRNAs were not allowed to adjust oxygen liter flow for residents because it would be considered administering oxygen and that was a nursing responsibility.  Interview with LPN #3 on 08/20/14 at 2:15 PM revealed nurses were required to look at Physician's Orders to ensure a resident was receiving the proper liter flow of oxygen. LPN #3 stated she was aware that Resident #7's oxygen was to be set at 3 liters per minute, but failed to adjust the flow. She stated she had not taken the time to "let it register" that she needed to change the oxygen to the correct liter flow.  Interview with LPN #2/the Unit Manager for the C, D, and E Wings on 08/20/14 at 2:25 PM revealed she completed room checks every morning to ensure that residents were getting proper care, which included checking to ensure correct oxygen liter flow and nurses were required to check resident oxygen liter flow every shift. Further interview with LPN #2 revealed that she was not aware Resident #7's oxygen had been set at the incorrect liter flow.  Interview with the DON on 08/20/14 at 4:20 PM revealed that she monitored residents' oxygen liter flow by doing random checks on her unit. The DON also stated that nurses were required to look at residents' Medication Administration Records (MAR) to ensure that residents were receiving oxygen at the correct liter flow. Further interview with the DON revealed that all department heads were assigned to do room	F 328			

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F 328	Continued From page 9 rounds daily to ensure proper care, including oxygen, was being provided.	F 328			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure a gradual medication dose reduction was attempted for one (1) of seventeen (17) sampled residents (Resident #10). Review	F 329	F 329  1. Resident 10 had a pharmacist review all medications including all psychoactives on 9/15/2014. Any recommendations for dosage reduction or medication related recommendations will be forwarded to the physician for review and recommendations by the DON.  2. Consulting pharmacist to review all residents receiving psychoactive medications by 9/22/2014 to identify any resident that may require a recommendation for reduction. Any issue identified will be immediately reported to the physician for recommendation review. DON to re-educate consulting pharmacist regarding review of all psychoactives per pharmacy policy to identify pharmacy tracking and knowledge. Completed 9/19/2014. IDT to review all residents medication list to identify any side effects being noted and to ensure pharmacy review schedule. Any issue identified will be reported to the physician for review/ recommendations.		

From:

09/18/2014 10:32

#576 P.003/004

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

 PRINTED: 09/05/2014  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/21/2014
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 10</p> <p>of documentation revealed on 07/12/13, Resident #10's physician prescribed Ativan (benzodiazepine hypnotic medication) for the resident on a daily basis. However, a review of the pharmacist recommendations revealed the pharmacist failed to recommend a gradual dose reduction (GDR) of the Ativan from 09/06/13 to 08/19/14 in an effort to determine the lowest effective dose of the medication for Resident #10.</p> <p>The findings include:</p> <p>Review of the facility's policy for Psychopharmacological Medication Use (revision date 01/01/13) revealed the facility would ensure the medication plan for residents would be reviewed and would consider a gradual dose reduction (GDR) for psychopharmacological medications for the purpose of finding the lowest effective dose, unless a GDR was clinically contraindicated.</p> <p>Review of the medical record revealed the facility admitted Resident #10 on 03/14/13 with diagnoses including Hypertension, Anxiety, Dementia, and Osteoporosis.</p> <p>Review of the annual comprehensive MDS assessment for Resident #10 dated 02/05/14, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. In addition, the resident was assessed to exhibit no episodes of anxiety or behaviors during the assessment reference period.</p> <p>Review of the physician's orders dated 07/12/13, revealed the physician prescribed 0.5 mg of</p>	F 329	<p>3. DON/ETD to re-educate Social Services, Pharmacy, Unit Managers and IDT related to use of psychoactives, side effects, lowest dosage use, and pharmacy policy to review. Completion 9/19/2014.</p> <p>UM/ETD to re-educate all licensed nurses regarding use of psychoactive, side effects, lowest dosage use, and pharmacy policy to review. Completion 9/19/2014.</p> <p>Social Services to maintain a current list of all psychoactives, last recommendation for reduction by pharmacy, any side effects and/or any change and when occurred beginning 9/15/2014.</p> <p>DON/ADON or UM to audit 10 residents monthly receiving psychoactives to note when began, last pharmacy review and last recommendation beginning 9/22/2014 x 6 weeks then 10 residents x 3 months or until QA team considers issue resolved.</p> <p>IDT to review any resident record within 10 days of any psychoactive order to ensure pharmacy aware and to ensure recommendation for follow up, beginning 9/22/2014 x 2 months.</p> <p>DON/ADON or UM to meet with Pharmacist monthly after review of resident's records to ensure all psychoactives are reviewed for reduction and that all medications are reviewed beginning 10/2014.</p>		

From:

09/18/2014 10:32

#576 P.004/004

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 09/05/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	Continued From page 11 Ativan to be administered two times a day for Resident #10. Review of the August 2014 MAR (Medication Administration Record) revealed Resident #10 received the medication as prescribed.  Review of the Consultant Pharmacist's reviews from 07/15/13 to 08/07/14 revealed the pharmacist had conducted a monthly regimen review for Resident #10 and on 09/06/13 (approximately two months after the Ativan had been prescribed) the pharmacist recommended a GDR for the use of the Ativan. However, continued review of documentation revealed no evidence the pharmacist had made any additional recommendations related to the use of the Ativan for Resident #10 during the timeframe of 09/06/13 to 08/19/14, a timeframe of eleven months.  Interview conducted with the Consultant Pharmacist on 08/21/14 at 3:50 PM, revealed she conducted monthly regimen reviews for residents at the facility. The Pharmacist acknowledged she had recommended one GDR for the Ativan on 09/06/13; however, she failed to consider a second recommendation.	F 329	4. QA team (consisting of at least the Medical Director, Administrator, Director of Nursing, ADON, UM, Social Services Director, and Life Enrichment Director) to review all audit findings and make revisions to plan as needed every week x 2 weeks beginning 9/23/2014, then at least Monthly or until issue resolved.  5. Date of compliance 9/24/2014.		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 332			

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F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.	F 332			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review.				

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F 332	<p>Continued From page 12</p> <p>and facility policy review, it was determined the facility failed to ensure the medication error rate was less than five (5) percent. During medication observation pass conducted on 08/19/14 and 08/20/14, thirty-three (33) medication opportunities were observed and two (2) errors were observed resulting in a six (6) percent medication error rate.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Administering Medications," with a revision date of April 2010, revealed medications would be administered in a safe and timely manner, and as prescribed. The policy noted the staff responsible for medication administration should check the medication labels three times to verify the right medication, right dosage, right time, and right method prior to giving the medication.</p> <p>According to the facility's General Dose Preparation and Medication Administration policy dated 12/01/07, facility staff should crush medications only in accordance with pharmacy guidelines and/or facility policy.</p> <p>1. A review of the physician orders dated August 2014 for Resident #1 revealed the resident's medication may be crushed and added to food if appropriate.</p> <p>A review of the facility's list of medications that should not be crushed (not dated) revealed Divalproex was listed as a medication that should not be crushed.</p> <p>A medication observation conducted for Resident #1 on 08/19/14 at 5:00 PM revealed Licensed</p>	F 332	<p>F 332</p> <p>1. Resident #1 and Resident G. physician and family was made aware of medication pass errors. No new orders noted. The Medical Director was made aware of Resident #1 and Resident G. medication errors, no new orders were noted.</p> <p>2. ETD/UM to conduct a one time medication pass audit of at least each nurse giving one resident 3 medications to be completed by 9/22/2014 to identify any medication pass errors to include crushing medications that should not be crushed. Any issue will be immediately reported to the physician and the nurse will be immediately re-educated prior to next medication being given. Any nurse not observed by 9/22/2014 will not work until EDT/UM observes medication pass to at least one resident getting three (3) medications.</p>		

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F 332	<p>Continued From page 13</p> <p>Practical Nurse (LPN) #5 prepared two medications (a Multivitamin and a Divalproex Sodium 250 milligram tablet, which is a medication used to treat seizures and mood disorders) for administration to Resident #1 by crushing the medications and mixing the medications with yogurt. The surveyor stopped LPN #5 at the resident's bedside prior to administration of the medication.</p> <p>An interview conducted with LPN #5 on 08/19/14 at 5:00 PM, revealed the LPN always crushed medications for Resident #1 because the resident would hold medications in his/her mouth and would not swallow the medication. Additional interview revealed LPN #5 was not aware Divalproex was a delayed release medication that should not be crushed.</p> <p>2. During the medication observation pass conducted on 08/20/14 at 8:40 AM, LPN #4 was observed to administer medications to Resident G. The LPN administered 10 individual tablets/capsules orally to the resident. However, the LPN failed to administer Norvasc (anti-hypertensive) 10 mg that was ordered by the physician to be administered daily at 9:00 AM.</p> <p>Interview conducted with LPN #4 on 08/20/14 at 9:10 AM, revealed the LPN had been trained to recheck the medication packages when documenting the medication on the resident's Medication Administration Record (MAR) to ensure each medication was administered as ordered by the physician. LPN #4 stated she "overlooked" the medication order for Norvasc for Resident G.</p> <p>An interview conducted with the Director of</p>	F 332	<p>3. UM/ETD/ADON to re-educate all licensed nurses regarding medication pass procedure and medications that cannot be crushed, completion 9/22/2014. UM/ETD/ADON to audit at least 2 nurses monthly passing medications to at least two (2) Residents x 3 months beginning 9/22/2014, then as QA team recommends. ETD to educate all new hire nurses regarding medication pass procedure to include medication crushing beginning 9/15/2014. Pharmacy to randomly audit at least 1 nurse administering medications to 2 residents quarterly beginning 10/2014.</p> <p>4. QA team (consisting of at least the Medical Director, Administrator, Director of Nursing, ADON, UM, Social Services Director, and Life Enrichment Director) to review all audit findings and make revisions to plan as needed every week x 2 weeks beginning 9/23/2014, then at least Monthly or until issue resolved.</p> <p>5. Date of compliance 9/24/2014.</p>		

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F 332	Continued From page 14 Nursing (DON) on 08/21/14 at 2.35 PM, revealed medication pass audits were completed on a random basis by the Education/Training Director and the DON to ensure nurses were trained and competent to administer medications to residents correctly.	F 332			
F 364 SS=C	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on facility policy review, interview, and record review, it was determined the facility failed to serve palatable food (mashed potatoes and green beans) to seventy-seven (77) of eighty-three (83) residents. The facility failed to season mashed potatoes and green beans for seventy (70) residents that received a diet of regular consistency and failed to serve pureed consistency green beans that were palatable to seven (7) residents that received foods of a pureed consistency.  The findings include:  Review of the facility's Menu policy dated December 2008, revealed the policy failed to address food palatability. However, review of the facility's diet manual (Simplified Diet Manual, 11th Edition, Iowa Dietetic Association) revealed a Regular (General) diet with no dietary	F 364	F 364  1. Resident # 5 who stated that the food was not seasoned and did not taste good was offered an alternative.  2. All residents have the potential to be affected. The meal served on the date of the test tray was prepared according to the menu. nevertheless the diets and the recipes will be reviewed for palatability and consistency. Salt and butter will be added to each meal tray so that residents may season foods according to their taste.		

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F 364	<p>Continued From page 15 modifications (except for consistency) would be served to the residents.</p> <p>Review of dietary documentation revealed 70 residents received diets of a regular consistency. In addition, seven residents received food items of a pureed consistency.</p> <p>The group interview was conducted at 3:00 PM on 08/19/14 with eight residents. The residents stated the food was not good and was not seasoned. In addition, Resident #5 stated in interview at 12:05 PM and 5:42 PM on 08/19/14 that the food was not seasoned and did not taste good.</p> <p>A test tray was requested and delivered to the B Wing at 6:00 PM. A palatability test was conducted, and the regular mashed potatoes and regular green beans tasted bland, and had no seasoning (e.g., salt) added. In addition, the taste of the garlic overpowered the taste of the pureed green beans.</p> <p>An interview conducted with the cook at 3:45 PM on 08/20/14 revealed salt had not been added to the regular mashed potatoes and green beans at the evening meal on 08/19/14. The cook further stated he/she added garlic and lemon pepper to the pureed green beans.</p> <p>Interview with the Registered Dietitian (RD) at 3:25 PM on 08/20/14 revealed salt was omitted from food because no residents were allowed to consume salt.</p>	F 364	<p>3. The Regional Dietician and Consultant Dietician will review the facility's diets and menus to determine if all resident's preferences and diet orders are being followed. In-services will be directed to the Dietary Manager and her staff to assure these orders, menus and preferences are being followed.</p> <p>4. QA team (consisting of at least Medical Director, The Administrator, DON and Dietary Manager) to review all audit findings and make revisions to the plan as need- Each week X 2 weeks beginning 9/23/2014 and then at least monthly or until issue is resolved</p> <p>5. Date of compliance 9/24/2014</p>		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	<p>Continued From page 16</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens 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:</p>	F 441	<p>F 441</p> <p>1. No resident identified. All residents have the potential to be affected. The Medical Director was made aware of linen placement on 8/21/2014 by the Administrator, no new recommendations.</p> <p>2. Laundry Supervisor to complete a random audit 2 x daily x 2 days of laundry personnel sorting, folding, and hanging linen to identify if any clean linens are on dirty laundry side of department. Any issue identified will be immediately corrected and laundry washed again. Completion date 9/22/14. Administrator conducted a one time audit of laundry on 8/21/14 to identify if clean linen was on dirty side. No issues identified.</p>		

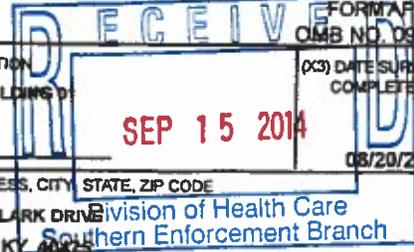
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F 441	<p>Continued From page 17</p> <p>Based on observation, interview, and a review of the facility's laundry policy, it was determined the facility failed to ensure staff handled, stored, and processed resident linens and clothing in a manner as to prevent the spread of infection. On 08/20/14, staff was observed to handle, sort, and hang clean resident clothing on a portable clothes rack that was located on the side of the laundry area that contained soiled linens/clothing.</p> <p>The findings include:</p> <p>A review of the facility laundry policy titled "Categories of a Laundry Operation," dated 01/01/00, revealed staff was to move laundry through the facility system from dirty to clean in the most efficient manner possible. Further review of the policy revealed personal clothing was folded or hung as it came from the dryer.</p> <p>Observations conducted with the Laundry Supervisor on 08/20/14 at 3:45 PM revealed clean and dirty sides of the laundry area were separated by a wall. Further observation revealed a laundry aide sorting and hanging clean resident personal laundry on the dirty side of the laundry in an area where dirty laundry was sorted.</p> <p>An interview conducted with the Laundry Supervisor revealed she monitored the laundry area once per week to ensure staff handled laundry appropriately to prevent the spread of infection. Further interview revealed staff was required to fold the clean laundry and hang the laundry on the clean side of the laundry area.</p>	F 441	<p>3. Laundry Supervisor to re-educate all laundry personnel by 9/22/2014 regarding laundry storage, laundry processes and laundry transport to prevent the spread of infection. Laundry Supervisor to audit department 3 x week x 4 weeks beginning week of 9/22/2014 then 1 x month x 2 months to ensure all personnel store, process and transport laundry to prevent the spread of infection. Administrator to audit laundry department 1 x week x 4 weeks then 1 time month x 2 months beginning week of 9/22/2014 to ensure all personnel store, process, and transport laundry to prevent spread of infection.</p> <p>4. QA team (consisting of at least the Medical Director, Administrator, Director of Nursing, ADON, UM, Social Services Director, and Life Enrichment Director) to review all audit findings and make revisions to plan as needed every week x 2 weeks beginning 9/23/2014, then at least Monthly or until issue resolved.</p> <p>5. Date of compliance 9/24/2014.</p>		

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NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475
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(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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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 1989  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type V (000)  SMOKE COMPARTMENTS: Seven  FIRE ALARM: Complete automatic fire alarm system.  SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.  GENERATOR: Type II diesel generator.  A life safety code survey was initiated and concluded on 08/20/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a	K 027	K 027  1. No single resident was identified to be affected by the deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Roy + Baber</i>	TITLE Administrator	(X5) DATE 9/5/14
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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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PRINTED: 09/05/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/20/2014
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475	
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K 027	<p>Continued From page 1</p> <p>20-minute fire protection rating or are at least 1½-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that cross-corridor fire/smoke barrier doors were maintained according to National Fire Protection Association (NFPA) standards. This deficient practice affected two (2) of seven (7) smoke compartments, staff, and approximately twenty-eight (28) residents. The facility has the capacity for 92 beds with a census of 84 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 08/20/14 at 11:30 AM with the Director of Maintenance (DOM), a set of cross-corridor fire/smoke barrier doors for the C and D Wing area were observed not to close all the way when tested. When tested the door edges rubbed and held the door, leaving approximately a one-half inch opening. These doors must close all the way to help prevent fire/smoke from spreading to other parts of the building in case of a fire situation.</p> <p>An interview with the DOM on 08/20/14 at 11:30</p>	K 027	<p>2. All residents have the potential to be affected by the deficient practice. Fire Doors identified on C and D wing have been adjusted to close all of the way not leaving a gap. All self closing fire doors have been reviewed and observed to close with no gaps/openings.</p> <p>3. The MD and Administrator will develop and follow a monitoring schedule to provide an assurance that all self closing fire doors meet the standard and close and meet so to provide a safe barrier. This monitoring will occur monthly.</p> <p>4. QA team (consisting of at least the Medical Director, Administrator, DON and Maintenance Director) to review all audit findings and make revisions to the plan as needed every week X 2 weeks beginning 9/23/2014, then at least monthly or until resolved.</p> <p>5. Date of compliance 9/24/2014.</p>	

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K 027	Continued From page 2 AM revealed he checked the fire doors approximately six weeks earlier and the doors operated as intended.	K 027		
K 038 SS=E	The findings were revealed to the Administrator upon exit. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain an exterior exit and exit access in accordance with National Fire Protection Association (NFPA) standards. The deficient practice affected three (3) of seven (7) smoke compartments, staff, and approximately sixty (60) residents. The facility has the capacity for 92 beds with a census of 84 on the day of the survey.  The findings include:  During the Life Safety Code tour on 08/20/14, at 10:15 AM, with the Director of Maintenance (DOM), a double exit door leading from the B Wing of the facility was observed to have time delayed magnetic locks. There was no signage	K 038		

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K 038	<p>Continued From page 3</p> <p>on the door, as required, on how to release the magnetic door lock in order to leave the facility in an emergency. In addition, the A Wing exit signage was also observed to be missing.</p> <p>An interview with the DOM on 08/20/14 at 10:15 AM revealed he was not aware how long the signage had been missing.</p> <p>On 08/20/14, at 12:55 PM, a corridor door to an office on the D Wing was observed to open and project more than seven inches into the corridor in the fully opened position. This condition could impede egress in an emergency and requires a door-closing device to remedy the situation.</p> <p>An interview with the DOM on 08/20/14, at 12:55 PM revealed he was not aware the door required a self-closing device.</p> <p>The findings were reported to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not</p>	K 038	<p>K 038</p> <ol style="list-style-type: none"> <li>1. No single resident was identified to be affected by the deficient practice.</li> <li>2. All residents have the potential to be affected by the deficient practice. The time delayed exit doors on A and B wing which were observed not to have signage with direction as to how to release the doors in case of an emergency now have signage. A door on D wing which was observed to open more than seven inches into the corridor and not have a self-closing device has had a device installed. The area where approved signage indicating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" was missing, this signage has been installed.</li> <li>3. The MD and the Administrator have observed all time delayed exit doors to be assured the required signage is in place and all doors are operating properly; observed and corrected any door which does not have a self closing appliance and opens</li> </ol>	

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K 038	<p>Continued From page 4</p> <p>more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>(d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>7.2.1.4.4*</p> <p>During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.)</p> <p>Exception: In existing buildings, a door providing access to a stair shall not be required to maintain</p>	K 038	<p>into a corridor; identified any double exit fire doors which do not open freely upon actuation of the emergency alarm and assured they operate as required. Monitoring of these areas will be performed monthly.</p> <p>4. QA team (consisting of at least the Medical Director, Administrator, and the DON) to review all audit findings and make revisions as needed every week X 2 weeks beginning 9/23/2014, then at least monthly or until resolved.</p> <p>5. Date of completion 9/24/2014.</p>	

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K 038	Continued From page 5 any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required width of a stair or landing when the door is fully open.	K 038	K 066		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:  (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.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoking areas according to National Fire Protection Association (NFPA)	K 066	1 .No single resident was identified to be affected by the deficient practice.  2. All residents have the potential to be affected by the deficient practice.  3. The areas designated to allow smoking have had installed metal self closing containers to allow for disposal of cigarette ashes and butts separately. The DM has observed all areas which allow smoking to have the required containers. This monitoring will be included in the DM monthly audits.  4. QA team ( consisting of at least the Medical Director, Administrator and DON) to review all audit findings and make revisions as needed every week X 2 weeks beginning 9/23/2014, then at least monthly or until resolved.  5. Date of completion 9/24/2014.		

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K 066	<p>Continued From page 6</p> <p>standards. This deficient practice could affect residents, staff, and other occupants of the building. The facility has the capacity for 92 beds with a census of 84 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 08/20/14 at 1:00 PM with the Director of Maintenance (DOM), a resident smoking area outside the facility, near the D Wing was observed not to have a metal self-closing container to empty cigarette ashtrays as required.</p> <p>An interview with the DOM on 08/20/14 at 1:00 PM revealed he was not aware smoking areas required self-closing metal containers to empty ashtrays contents. The DOM stated he did not have access to Life Safety Code requirements in the performance of his job duties.</p> <p>The findings were revealed to the Administrator upon exit.</p>	K 066			