

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

PRINTED: 07/24/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2014
NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42346		
(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 159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p>	F 159	F159 - Deficiency - 483.10(c)(2)-(5) - Please see attached Plan of Correction page 1 for actions taken.	7/29/14	

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

TITLE

(X6) DATE

Bucky Jagers, NHA

Administrator

9/14/14

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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F 159	<p>Continued From page 1</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to assure a system was in place, for resident funds in excess of \$50.00, to have been deposited into an interest bearing account, for two (2) of three (3) sampled residents (Residents #11 and #12) who used the accounts.</p> <p>The findings include:</p> <p>Interview with the facility's Director of Accounting, on 07/09/14 at 2:45 PM, revealed he was unaware of any specific facility policy for the resident accounts to have been maintained in an interest bearing account.</p> <p>Review of the resident accounts, revealed Resident #11 had a balance on hand of \$783.66 and Resident #12 had a balance of \$83.72, as of 07/09/14. Further review revealed there was no documented evidence of any accrued interest or</p>	F 159			

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F 159	Continued From page 2 of the funds being held in an interest bearing account. Interview with the Resident Accounts Manager, on 07/09/14 at 10:37 AM, revealed the accounts had not been interest bearing for several years, but was not sure why or what transpired to change the old system. Interview with the Director of Accounting, on 07/09/14 at 2:45 PM, revealed he had only been employed, in that position for a short time and was unaware of this regulation. He made phone calls to determine what had occurred and stated sometime in 2010, the bank was going to charge the facility a monthly maintenance fee for any accounts that were under the designated amount balance and in order to avoid this fee the resident accounts were placed in non-interest bearing accounts. Interview with the Director of Nursing (DON,) in charge for the Administrator, on 07/10/14 at 12:00 PM, revealed she was aware the resident accounts were supposed to be in interest bearing accounts and stated she was not aware until 07/09/14, that they were not.	F 159			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241	F241 - Deficiency - 483.15(a) - Please see attached Plan of Correction page 2 for actions taken.	8/1/14	

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F 241	<p>Continued From page 3</p> <p>Based on observation, interview, and review of the facility's policy and procedure it was determined the facility failed to promote dignity to one (1) of ten (1) sampled residents (Resident #6). Staff provided incontinent care to Resident #6 and failed to close the privacy curtain.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure Subject: Dignity, effective date January 2013, revealed residents shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Further review revealed staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p> <p>Record review revealed Resident #6 was admitted to the facility on 06/01/12 with diagnoses which included status post (s/p) Cerebrovascular Accident (CVA), Atrial Fibrillation (AFib), Congestive Heart Failure (CHF), and Depression. Review of the Annual Minimum Data Set (MDS) assessment, dated 04/15/14, revealed the facility assessed Resident #6's cognition as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fourteen (14) which indicated the resident was interviewable.</p> <p>Observation, on 07/08/14 at 10:40 AM, revealed Resident #6 receiving incontinent care provided by Certified Nursing Assistant (CNA) #4 with the assistance of CNA #3. The privacy curtain was not closed.</p> <p>Interview with Resident #6, on 07/08/14 at 4:10 PM, revealed the resident felt embarrassed when</p>	F 241			

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F 241	Continued From page 4 the privacy curtain was not pulled to provide privacy. Interview with CNA #3, on 07/08/14 at 3:50 PM, revealed the resident should have been provided privacy prior to the care being performed. She stated, "The privacy curtain should be closed". Interview with CNA #4, on 07/08/14 at 3:55 PM, revealed the resident should have been provided privacy for dignity while care was performed. Interview with the Director Of Nursing (DON), on 07/09/14 at 11:50 AM revealed her expectation is for privacy curtain to be used at all times when residents receiving care.	F 241			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and a review of the facility policy, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, related to improper storage of supplies. Observations revealed mattresses, floor mats, wheel chair foot rests and sharps containers stored on the floor in the Soiled Utility Room and the Storage Rooms on both floors; Personal Protective Equipment (PPE) was stored in the second floor Soiled Utility Room; and, clean linens were touching the floor	F 253	F253 - Deficiency - 483.15(h)(2) - Please see attached Plan of Correction pages 3 - 4 for actions taken.	8/1/14	

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F 253	<p>Continued From page 5 in the first floor Clean Linen Room.</p> <p>The findings include:</p> <p>Review of the facility's Policy and Procedure for the Clean and Soiled Linen Rooms and for Material and Equipment, dated February 2012, revealed the Clean Linen Room and the Soiled Utility Room were to have been inspected after use to ensure that furnishings were in the proper place, any needed repairs were reported, equipment was clean and stored properly and replaced in an orderly fashion with linens covered and protected from contamination and any deficiencies corrected.</p> <p>1. Observation of the Second Floor Soiled Utility Room, on 07/09/14 at 8:00 AM, revealed two (2) mattress, six (6) floor mats, three (3) sets of wheel chair foot rests and two (2) sharps containers were stored on the floor. In addition, boxes of gloves and folded gowns were noted in the PPE over-the-door container that was placed on the shelf.</p> <p>2. Observation of the First Floor Soiled Utility Room, on 07/09/14 at 8:30 AM, revealed two (2) mattresses, a back board, two (2) sets of wheel chair foot pedals, cardboard boxes stored on the floor and there was a broom stored on the floor, behind the hopper.</p> <p>3. Observation of the First Floor Linen Room, on 07/09/14 at 8:45 AM, revealed six (6) stacks of folded linens, on the bottom shelves were touching the floor.</p> <p>Interview with Registered Nurse (RN) #2, on 07/09/14 at 8:15 AM revealed she was unsure</p>	F 253			

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F 253	Continued From page 6 why the PPE was stored in this room, as the equipment had not been in the room of a resident on contact isolation and only hung outside the door and would not have been contaminated and should not have been placed in the Soiled Utility Room. She also stated the other equipment should not have been placed in the floor. Interview with the Maintenance Director/Housekeeping Supervisor, on 07/09/14 at 8:20 AM, revealed nothing should have been stored in the floor and linens should never touch the floor. He stated the staff members had been trained upon hire and periodically, as to this practice. He stated he made rounds monthly to each room, to check for any non compliance and the staff members were usually good to let him know if anything needed his attention. Interview with the Director of Nursing (DON), in charge for the Administrator on 07/10/14 at 8:10 AM, revealed the PPE container was usually stored in the clean linen room and was unsure why it had been placed in the soiled utility but the supplies had been thrown away. She stated staff members had been trained upon hire as to how supplies were to have been stored and the Staff Development Coordinator re-inserviced on this, at least annually.	F 253			
F 323 SS=D	483.25(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.	F 323	F323 - Deficiency - 483.25(h) - Please see attached Plan of Correction page 5 for actions taken.	8/1/14	

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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the resident's environment remained as free from accident hazards as possible, related to observations of resident rooms (#101 and #109) that revealed aerosol hair sprays were improperly stored. The Findings include: Interview with the Plant Operations Manager and the Director of Nursing (DON), on 07/10/14 at 12:30, revealed there was no written policy regarding the storage of aerosol hair spray. Observation of Room #106 and #108 on 07/08/14 from 11:10 AM until 11:16 AM, revealed two (2) cans of aerosol hair spray, one on each of the resident shelves, with caution labels that read "Caution: Flammable." Interview with the Director of Nursing (DON), on 07/10/14 at 12:15 PM, revealed that she was not aware any resident had aerosol hair spray in their rooms and that she was aware these were flammable and should not have been in the resident's rooms. Interview with the Plant Operations/Safety Director, on 07/10/14 at 12:30 PM, revealed the facility tried to discourage the use of all aerosol hair sprays and encourage the use of the pump mist hair spray instead and stated aerosol hair sprays were flammable and the facility needed to	F 323			

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F 323	Continued From page 8	F 323			
F 371 SS=E	<p>have added that to the list of items residents were not allowed to bring into the facility.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen revealed the range hood with a build up of dust and debris over the cooking stove; peeling paint on the floor of the walk-in refrigerator; a build up of a brown substance on the metal cover inside the ice machine; standing water, wet cardboard pieces and debris around the grease collection dumpster; and spices with dates from 2008 and 2010.</p> <p>Review of the facility's Census and Condition, dated 06/30/14, revealed there were (thirty-three) 33 residents in the facility and two (2) of those residents were tube feeders and did not eat food from the kitchen area.</p> <p>The findings include:</p>	F 371	F371 - Deficiency - 483.35(i) - Please see attached Plan of Correction pages 6 - 7 for actions taken.	8/12/14	

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F 371	<p>Continued From page 9</p> <p>1. Observation of the range hood and exhaust area over the stove, on 07/09/14 at 11:15 AM, revealed a build up of dust, grease and debris covering the surface of the area.</p> <p>Review of the "Service Report and Courtesy Cleaning Report," dated 01/02/14, revealed the ductwork, access panels and the roof surface of the range hood was last cleaned on 01/02/14.</p> <p>Interview with the Dietary Manager (DM), on 07/09/14 at 11:30 PM, revealed the range hood area was cleaned every six months by a contract company and the DM stated the area should be cleaned every three (3) months but there was no money budgeted for this expense.</p> <p>Interview with the Director of Plant Operations, on 07/10/14 at 12:20 PM, revealed the build up on the range hood could be cleaned more often, it just needed to be a part of the budgeted operations for the Dietary Department.</p> <p>2. Interview with the DM, on 07/09/14 at 11:30 PM, revealed there was no policy for the peeling paint.</p> <p>Observation of the walk-in refrigerator, on 07/09/14 at 11:15 AM, revealed long rows of peeling paint on the floor of the refrigerator with a build up of debris in the rows.</p> <p>Interview with the DM, on 07/09/14 at 11:25 AM, revealed the refrigerator floor was painted approximately one (1) year ago and the paint did not properly dry before the refrigerator was used. She stated the carts coming in and out caused the paint to stick on the wheels of the carts,</p>	F 371			

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F 371	<p>Continued From page 10</p> <p>causing the damage to the floor. There were plans in place to repaint, however, there had not been an opportune time to secure all the items necessary for this.</p> <p>Interview with the Manager of Plant Operations, on 07/10/14 at 12:20 PM, revealed he was not aware the paint had peeled and stated the walk-in was painted due to a recommendation made by the Health Department.</p> <p>3. Observation of the ice cooler, on 07/09/14 at 11:30 AM, revealed a build up of rust colored substances on the metal plate over the ice.</p> <p>Review of the "Ice Machine Sanitizing Log," dated January 2010, revealed the ice machine was scheduled to have been cleaned monthly on the twentieth (20 th) of the month and was last cleaned on 06/20/14.</p> <p>Interview with the Dietary Manager, on 07/10/14 at 11:00 AM, revealed the ice machine was routinely cleaned on a monthly basis and stated a thorough cleaning of the metal plate over the ice should have been done more frequently.</p> <p>4. Interview with the DM, on 07/09/14 at 11:30 PM, revealed there was no policy for cleaning around the dumpsters.</p> <p>Observation of the dumpster area, on 07/11/14 at 11:00 AM, revealed the grease collection dumpster was silling in approximately six (6) inches of water at the back of the concrete pad and the pad was noted to have pieces of wet cardboard and debris, floating in the water.</p> <p>Interview with the DM, on 07/10/14 at 11:10 AM,</p>	F 371			

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F 371	Continued From page 11 revealed the facility had to construct a concrete pad for this dumpster, to include concrete bumpers to surround the pad in case of a grease spill. However, there had been no monitoring or cleaning of the site for a build up of water and debris. Interview with the Manager of Plant Operations, on 07/10/14 at 12:20 PM, revealed the areas around the dumpsters were to be cleaned by the custodial staff and was unaware how often this was scheduled. 5. Review of the facility's policy, "What Is the Shelf Life of Spices," dated 07/09/14, revealed "ground spices will keep for one year." Observation of the spice rack, on 07/09/14 at 11:30 AM, revealed a sixteen (16) ounce container of Sage, dated 05/13/14 and a sixteen (16) ounce container of Ginger, dated 05/26/08. Interview with the DM, on 07/10/14 at 11:00 AM, revealed the policy stated the ground spices were good for one (1) year and spices older than this should have been eliminated from the shelves.	F 371			
F 441 SS=E	483.65 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 -	F 441	F441 - Deficiency - 483.65 - Please see attached Plan of Correction page 8 for actions taken.	8/1/14	

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345		
(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 441	<p>Continued From page 12</p> <p>(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.</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. (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.</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: Based on observation, interview and review of the facility policy, it was determined the facility staff failed to perform proper hand washing and gloving technique for four (4) of ten (10) sampled residents (Residents #1, #2, #6 and #8).</p> <p>The findings include: Review of the facility's policy and procedure titled,</p>	F 441			

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F 441	<p>Continued From page 13</p> <p>"Hand Hygiene & Respiratory Etiquette," dated as reviewed April 2014, revealed "hand hygiene is the single most important means of preventing the health care worker from transmitting infection to patient and themselves. You should wash your hands before and between serving food, after removing gloves, after touching objects of a patient's environment and after touching a patient." Further review of the policy revealed the staff were to have removed their gloves after caring for a patient and when wearing gloves, they were to have changed or removed gloves during patient care, if moving from a contaminated body site to another body site or the environment.</p> <p>1. Record review revealed the facility admitted Resident #2 on 11/12/13 with diagnoses which included Sleep Apnea, Anemia, Dementia, and Sacrum Decubitus. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 05/06/14, revealed the facility assessed Resident #2 as having an indwelling catheter.</p> <p>Observations during catheter care for Resident #2, on 07/09/14 at 1:50 PM, revealed Certified Nurse Aide (CNA#2) failed to change gloves after providing catheter care and touched Resident #2's shoulder, bedding, positioning wedge and emptied the resident's urinary drainage bag, touching the outlet drainage valve, using the same gloves used during catheter care.</p> <p>Interview with CNA#2, on 07/09/14 at 2:25 PM, revealed he/she should have washed his/her hands and put on a new pair of gloves after providing catheter care and before continuing to provide other care to Resident #2, to prevent the spread of infection throughout the room and to</p>	F 441			

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F 441	<p>Continued From page 14 the resident.</p> <p>2. Record review revealed Resident #8 was admitted to the facility on 06/23/14 with diagnoses which included Rehabilitation, Incontinence and Multiple Sclerosis. Review of the Admission MDS Assessment, dated 06/23/14, revealed the facility assessed the resident as being incontinent of bladder, and needing the assistance of two (2) staff with hygiene and toileting.</p> <p>Observation of incontinent care for Resident #8, on 07/09/14 at 8:45 AM, revealed CNA#1 failed to remove her gloves after providing incontinent care, and touched the resident's bare shoulder, both feet, pillows, ice pack and the bedside table.</p> <p>Interview with CNA#1, on 07/10/14 at 11:45 AM, revealed she should have changed her gloves after providing incontinent care to prevent the spread of infection.</p> <p>Interview with the Director of Nursing (DON), on 07/10/14 at 11:45 AM, revealed she expected the staff to have changed their gloves after catheter care and pericare and to have washed their hands and put on a fresh pair of gloves, prior to the continuation of provision of care to the resident.</p> <p>3. Record review revealed the facility admitted Resident #6 on 06/01/12, with diagnoses which included Hypertension, Cerebrovascular Accident with Right-Sided Hemiparesis, Muscle Weakness, Insomnia, Chronic Urinary Tract Infections, Atrial Fibrillation, Chronic Heart Failure and Depression. Review of the Quarterly MDS Assessment, dated 07/08/14, revealed the facility assessed the resident as being incontinent of</p>	F 441			

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F 441	<p>Continued From page 15</p> <p>bowel and bladder and needed the assistance of two (2) staff with incontinent care.</p> <p>Observations during incontinent care for Resident # 6, on 07/09/14 at 9:10 AM, revealed CNA#3 failed to change her gloves after cleaning stool and cleaned the resident's inner thighs.</p> <p>Interview with CNA #3, on 07/09/14 at 9:20 AM, revealed that she should have changed gloves after cleaning the resident's buttocks, prior to cleaning the front side.</p> <p>Interview with CNA #4, on 07/09/14 at 3:22 PM, revealed he should have changed his gloves after cleaning the rectal area, prior to cleaning the resident's inner thighs.</p> <p>4. Record review revealed the facility admitted Resident #1 on 11/12/12 with diagnoses to include Diabetes, Hyperlipidemia, Depressive Disorder, and Gastroesophageal Reflux.</p> <p>Observation, on 07/09/14 at 2:50 PM of indwelling catheter care, revealed CNA #4 failed to remove gloves and wash his hands after emptying a urinary drainage bag prior to leaving the room. Further observation revealed CNA #4 left the room with the same pair of gloves on, went into soiled linen room, and went back into room #261 before removing gloves and washing his hands.</p> <p>Interview with CNA #4 on 7/9/14 at 3:00 PM revealed he should wash hands after emptying urine drainage bag. Further interview revealed gloves should be removed and hands washed prior to leaving residents room.</p> <p>Interview with Licensed Practical Nurse (LPN) #1</p>	F 441			

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F 441	Continued From page 16 on 7/10/14 at 11:15 AM revealed she would expect CNA to wash hands prior to leaving resident room . Interview with DON, on 7/10/11/at 11:50 AM revealed her expectation was for hands to be washed prior to leaving an area after a task is completed. Further interview revealed hands should be washed before applying a new pair of gloves.	F 441			

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NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345
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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: 1966.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II (222).</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, and upgraded in 1984 with 191 smoke detectors and 14 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1998.</p> <p>GENERATOR: Type I generator installed in 1984. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 07/09/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty-five (45) beds with a census of thirty-three (33) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Becky Jacques, RN</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/25/14</i>
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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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K 000	Continued From page 1 Fire).	K 000			
K 011 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "E" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire wall was in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for forty-five (45) beds and at the time of the survey, the census was thirty-three (33).</p> <p>The findings include:</p> <p>Observation, on 07/09/14 at 11:10 AM with the Director of Plant Operations, revealed the two (2) hour wall separating the skilled nursing facility from the hospital at the surgery hall had doors and frame installed that did not have fire rating tags applied.</p>	K 011	K011 - Deficiency - NFPA 101 - Please see attached Plan of Correction page 1 for actions taken.	9/12/14	

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K 011	<p>Continued From page 2</p> <p>Interview, on 07/09/14 at 11:10 AM with the Director of Plant Operations, revealed he knew the doors had a fire rating but could not find any documentation for the rating of the doors.</p> <p>Observation, on 07/09/14 at 11:10 AM with the Director of Plant Operations, revealed the two (2) hour wall separating the skilled nursing facility from the hospital at the end of the first floor had doors and frame installed that had paint covering the fire rating tags.</p> <p>Interview, on 07/09/14 at 11:10 AM with the Director of Plant Operations, revealed he was unaware the fire rating tags could not be painted over.</p> <p>The census of thirty-three (33) was verified by the Administrator on 07/09/14. The findings were acknowledged by the Chief Executive Officer and verified by the Director of Plant Operations at the exit interview on 07/09/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations. 19.1.1.4.1 Additions. Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.6.6.) 19.1.1.4.2 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in</p>	K 011		

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K 011	Continued From page 3 corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.) 19.1.1.4.3 Doors in barriers required by 19.1.1.4.1 shall normally be kept closed. Exception: Doors shall be permitted to be held open if they meet the requirements of 19.2.2.2.6.	K 011		
K 147 SS=E	8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147 - Deficiency - NFPA 101 - Please see attached Plan of Correction page 2 for actions taken.	8/8/14

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K 147	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for forty-five (45) beds and at the time of the survey, the census was thirty-three (33).</p> <p>The findings include:</p> <p>Observation, on 07/09/14 at 11:30 AM with the Director of Plant Operations, revealed an extension cord plugged into a television located in resident room #118.</p> <p>Interview, on 07/09/14 at 11:31 AM with the Director of Plant Operations, revealed he was unaware of the extension cord being used for the television. He stated the facility completes audits to ensure proper electric connections were in the facility.</p> <p>Observation, on 07/09/14 at 11:40 AM with the Director of Plant Operations, revealed an extension cord plugged into a microwave located in canteen on the first floor.</p> <p>Interview, on 07/09/14 at 11:41 AM with the Director of Plant Operations, revealed he was unaware of the extension cord being used for the microwave. He stated the facility completes audits to ensure proper electric connections were in the facility.</p> <p>Observation, on 07/09/14 at 12:00 PM with the</p>	K 147		

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K 147	<p>Continued From page 5</p> <p>Director of Plant Operations, revealed an extension cord plugged into a microwave located in kitchen on the second floor.</p> <p>Interview, on 07/09/14 at 12:01 PM with the Director of Plant Operations, revealed he was unaware of the extension cord being used for the microwave. He stated the facility completes audits to ensure proper electric connections were in the facility.</p> <p>Observation, on 07/09/14 at 12:20 PM with the Director of Plant Operations, revealed an extension cord plugged into another extension cord located in the conference room on the second floor.</p> <p>Interview, on 07/09/14 at 12:21 PM with the Director of Plant Operations, revealed he was unaware of the extension cord being used. He stated the facility completes audits to ensure proper electric connections were in the facility.</p> <p>The census of thirty-three (33) was verified by the Administrator on 07/09/14. The findings were acknowledged by the Chief Executive Officer and verified by the Director of Plant Operations at the exit interview on 07/09/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 edition)3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147			

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K 147	Continued From page 6 Reference: NFPA 70 (1999 Edition). 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147			