



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

PRINTED: 10/08/2015  
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 Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED  09/24/2015
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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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F 000  F 332 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted on 09/22-24/15. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p><b>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b></p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy it was determined the facility failed to ensure the medication error rate was five (5) percent or less. During medication administration observation on 09/23/15, twenty-seven (27) opportunities were observed and two (2) errors were observed, resulting in a medication error rate of seven (7) percent.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Administering Medications," dated April 2010, revealed the facility would administer medications in a safe and timely manner, and as prescribed by the physician.</p> <p>Observation of medication administration on 09/23/15 at 8:55 AM revealed Licensed Practical Nurse (LPN) #1 administered Vitamin C 500 milligrams (mg), Magnesium Oxide 400 mg, Namenda XR 28 mg, Zinc 30 mg, Aspirin 81 mg, Pantoprazole 40 mg, Potassium 10</p>	F 000  F 332	<p>I. Resident #4 was not affected by the alleged deficient practice. The Vitamin C 500 mg was discontinued and the resident's physician was made aware, by the Unit Manager, of the error and of the omission of one dose of the Metoprolol Succinate ER 25 mg. The physician did not order further monitoring.</p> <p>II. The medication orders of all residents were reviewed on 09/25/15 and 09/28/15 and no other errors were identified.</p> <p>III. A root cause analysis was completed on 09/28/15 to ensure the Quality Assurance Performance Improvement (QA/PI) Committee understood the error that created the alleged deficient practice. The QA/PI Committee consists of the Medical Director, all department managers, and SRNA's and Licensed Staff.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm	(X6) DATE 10-28-15
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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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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 332	<p>Continued From page 1</p> <p>milliequivalents (mEq), Sertraline HCL 100 mg, Zinc 220 mg, Proscar 5 mg, Cholestyramine mixed with 2 to 6 ounces of water, and Lyrica 300 mg to Resident #4.</p> <p>Review of the Medication Administration Record (MAR) and the physician's orders on 09/23/15 at 3:00 PM revealed Resident #4 was ordered Metoprolol Succinate ER 25 mg daily in the morning. Further review of the physician's orders revealed an order written on 09/04/15 to discontinue Vitamin C 500 mg in 14 days.</p> <p>Interview with LPN #1 on 09/23/15 at 3:35 PM revealed she gave the Vitamin C 500 mg because it was on the MAR to give and had not been discontinued. She further revealed she thought she had given the Metoprolol Succinate ER 25 mg to Resident #4 with the morning medication administration.</p> <p>Interview with the Unit Manager on 09/23/15 at 4:13 PM revealed she checked orders daily to ensure the orders were entered into the computer or discontinued out of the computer. She further revealed she watched nurses daily, during medication administration, to ensure the nurses were accurately administering medications and stated she had not identified any concerns.</p> <p>Interview with the Director of Nursing (DON) on 09/23/15 at 3:55 PM revealed the nurses and the Unit Managers were responsible to ensure the MAR was updated and updated in the computer when there were changes to medication orders. She further revealed the Pharmacist also checked each nurse off on medication administration two times per year to ensure that medications were being administered correctly.</p>	F 332	<p>III. Both Unit Managers were educated by the Education and Training Director on 09/28/15 to run a new order Report, daily, Monday through Friday, to use as a tool to audit that all orders were correctly entered on the MAR or the TAR.</p> <p>A monthly audit of all physicians' orders is conducted by each Unit Manager to ensure all orders have been entered on the MAR or the TAR.</p> <p>The Pharmacy Consultant has agreed to observe a medication pass with one nurse every month. The Pharmacy Consultant began making these observations in October. In addition to this monthly observation, the DON, ADON, and each Unit Manager will complete two medication pass observations each month, observing medication passes on both shifts.</p>		

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F 332	<p>Continued From page 1</p> <p>milliequivalents (mEq), Sertraline HCL 100 mg, Zinc 220 mg, Proscar 5 mg, Cholestyramine mixed with 2 to 6 ounces of water, and Lyrica 300 mg to Resident #4.</p> <p>Review of the Medication Administration Record (MAR) and the physician's orders on 09/23/15 at 3:00 PM revealed Resident #4 was ordered Metoprolol Succinate ER 25 mg daily in the morning. Further review of the physician's orders revealed an order written on 09/04/15 to discontinue Vitamin C 500 mg in 14 days.</p> <p>Interview with LPN #1 on 09/23/15 at 3:35 PM revealed she gave the Vitamin C 500 mg because it was on the MAR to give and had not been discontinued. She further revealed she thought she had given the Metoprolol Succinate ER 25 mg to Resident #4 with the morning medication administration.</p> <p>Interview with the Unit Manager on 09/23/15 at 4:13 PM revealed she checked orders daily to ensure the orders were entered into the computer or discontinued out of the computer. She further revealed she watched nurses daily, during medication administration, to ensure the nurses were accurately administering medications and stated she had not identified any concerns.</p> <p>Interview with the Director of Nursing (DON) on 09/23/15 at 3:55 PM revealed the nurses and the Unit Managers were responsible to ensure the MAR was updated and updated in the computer when there were changes to medication orders. She further revealed the Pharmacist also checked each nurse off on medication administration two times per year to ensure that medications were being administered correctly.</p>	F 332	<p>All licensed staff have been provided additional training in order-entry. This education was completed on 10/22/15. All new staff members who pass medications will be trained in order entry by the Education and Training Director. The Education and Training Director will also be responsible for providing competencies for new licensed nurses and Kentucky Medication Assistants (KMA's) for compliance with medication pass for orientation and annual evaluations.</p> <p>IV. The findings of the Unit Managers' audits and all other audits, including any completed related to compliance concerns will be presented to the Quality Assurance Performance Improvement Committee (QA/PI) each month. The QA/PI Committee consists of the Medical Director, all department managers and as well as SRNA's and Licensed Staff. The QA/PI Committee will determine the frequency to conduct further audits.</p>		

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F 332	Continued From page 2 No concerns had been identified with medication administration.	F 332	The QA/PI Committee will review the findings of the pharmacist's, DON's, and ADON's medication pass observations each month to determine education needs and the need for continued monthly medication pass observations by the pharmacist.	10/23/15
F 441 SS=D	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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		

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NAME OF PROVIDER OR SUPPLIER  <b>MADISON HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>131 MEADOWLARK DRIVE RICHMOND, KY 40475</b>	
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F 441	<p>Continued From page 3 infection.</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 provide an effective infection control program to help prevent the development and transmission of disease and infection as evidence observation on 09/23/15 revealed staff failed to wash their hands or change gloves after dropping a tube of ointment onto the floor. Staff was observed to then pick up the ointment with the soiled gloves and continue to apply the ointment to Resident #4's groin area.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Infection Control Guidelines for All Nursing Procedures," dated April 2013, revealed staff was required to wash hands and change gloves after contact with a resident's intact skin and after contact with objects, such as medical equipment, in the vicinity of the resident.</p> <p>Observations conducted during wound care treatment on 09/23/15 at 10:25 AM revealed Licensed Practical nurse (LPN) #2 was applying Calmoseptine Ointment on Resident #4's groin area. Observations revealed LPN #2 dropped the tube of ointment onto the floor, retrieved the tube of ointment, and continued to apply the Calmoseptine Ointment to Resident #4's groin area without washing her hands or changing her</p>	F 441	<p>III. The Education and Training Director provided training for all current and new staff about hand washing and appropriate use of gloves when dropping something on the floor. This training was completed on 10/22/15.</p> <p>The Infection Control Committee made up of the Director of Nursing, Assistant Director of Nursing, Unit Managers, SRNA's and Licensed staff, Housekeeping Supervisor, and Dietary Manager, will be making observations of care to observe opportunities for hand washing, 20 observations per week.</p>	

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F 441	Continued From page 4 gloves.  Interview conducted with LPN #2 on 09/23/15 at 10:45 AM revealed she was nervous because she was being observed and forgot to change her gloves and wash her hands after picking up the ointment tube from the floor.  Interview with the Infection Control Nurse on 09/24/15 at 4:59 PM revealed she selected staff randomly during the week and observed them for compliance with facility policy and hand hygiene as they provided care to residents. Further interview revealed she had not identified any concerns related to staff, including LPN #2, failing to sanitize their hands and/or change gloves when indicated.	F 441	IV. The Quality Assurance Performance Improvement Committee (QA/PI) will review the hand washing observations every month in the QA/PI Committee meeting to determine whether the need exists for further hand washing education and/or increased frequency of observations. The threshold for compliance will be 90%. The QA/PI Committee consists of the Medical Director, all department managers, SRNA's and Licensed staff.	10/23/15	

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 185262	<b>(Y2) Multiple Construction</b> A. Building B. Wing	<b>(Y3) Date of Revisit</b> 11/2/2015
<b>Name of Facility</b> MADISON HEALTH AND REHABILITATION CENTER		<b>Street Address, City, State, Zip Code</b> 131 MEADOWLARK DRIVE RICHMOND, KY 40475

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0332</u> Reg. # <u>483.25(m)(1)</u> LSC _____	Correction Completed <u>10/23/2015</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>10/23/2015</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>ad</u>	Reviewed By <u>ad</u>	Date: <u>11/18/15</u>	Signature of Surveyor: <u>Alisia Dunn</u>	Date: <u>11/18/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>9/24/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

**State Form: Revisit Report**

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 100454	<b>(Y2) Multiple Construction</b> A. Building B. Wing	<b>(Y3) Date of Revisit</b> 11/2/2015
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<b>Name of Facility</b> MADISON HEALTH AND REHABILITATION CENTER	<b>Street Address, City, State, Zip Code</b> 131 MEADOWLARK DRIVE RICHMOND, KY 40475
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>N0150</u> Reg. # <u>902 KAR 20:300-6(7)(b)2.d.</u> LSC _____	Correction Completed <u>10/23/2015</u>	ID Prefix <u>N0237</u> Reg. # <u>902 KAR 20:300-8(12)(c)1.</u> LSC _____	Correction Completed <u>10/23/2015</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>ad</u> State Agency	Reviewed By <u>ad</u>	Date: <u>11/18/15</u>	Signature of Surveyor: <u>Alisia Dunn</u>	Date: <u>11/18/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>9/24/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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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 09/24/15. 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 "D" level.	K 000	I. The door for resident room 41 was repaired and now latches when closed.  The hardware is now mounted correctly to resident room 34 and the door latches.  The fall mats in room 37 were moved to prevent anything from obstructing the door closing.  The door to resident room 42 was repaired using fire-rated weather strip to ensure there was no gap at the top of the door.  All repairs were made by the Maintenance Supervisor.  II. All other doors in the facility were inspected and found to have no obstruction or disrepair that prevented any door from latching.  All other doors in the facility were inspected and doors with gaps were repaired or replaced so that no gaps existed.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than	K 018		

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

TITLE

(X8) DATE

*[Handwritten Signature]*

*[Handwritten Title: Adm]*

*[Handwritten Date: 10-16-15]*

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

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NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40476		
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K 018	<p>Continued From page 1</p> <p>required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, which includes twenty-four (24) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 09/24/15 at 10:24 AM, with the Maintenance Director, revealed the door for resident room 41 would not latch when closed. Further observation revealed the hardware for the door to resident room 34 was not mounted</p>	K 018	<p><b>III.</b></p> <p>The Maintenance Director has been educated by the Regional Plant Operations Manager about how to perform audits of doors within the facility to ensure all doors latch properly and have no gaps.</p> <p>Nursing staff have been educated regarding the placement of resident equipment; placing items in a manner that does not impede the closing of doors.</p> <p><b>IV.</b></p> <p>An audit of doors will be completed by the Administrator or Maintenance Supervisor, one unit per month, for six months. The findings of these audits will be presented to the Quality Assurance Performance Improvement Committee. The Committee consists of the Medical Director, all department managers, and SRNA's and Licensed staff.</p>	10/23/15

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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  09/24/2015	
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
K 018	<p>Continued From page 2</p> <p>correctly and the door would not latch. The door of resident room 37 had a fall mat, which obstructed the door from closing. In addition, the door for resident room 42 was observed to have a gap at the top of the door. Interview with the Maintenance Director at the time of observation revealed Maintenance inspected the doors monthly to ensure corridor doors are meeting Code. The Maintenance Director stated no problems had been identified with the doors.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is</p>	K 018		

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K 018	Continued From page 3 acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire	K 029	I. The combustible items were removed from the sprinkler control room. The wooden chock was removed from the sprinkler control room by the Maintenance Supervisor.  II. All boiler, sprinkler, laundry, and other areas within the facility where combustible items are prohibited from being stored were inspected. No other areas had any combustible materials stored.	

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K 029	<p>Continued From page 4</p> <p>Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty-two (22) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 09/24/15 at 10:09 AM, with the Maintenance Director revealed the sprinkler control room was being used to store combustible items (medical supplies in cardboard boxes). Further observation revealed a wooden choke (used to prevent movement) was located behind the door. The facility failed to use an approved device to hold open the door to this room. Interview with the Maintenance Director at the time of observation revealed staff used the wooden choke to prop the door open so staff could remove items from the room.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>) (3) Paint shops</p>	K 029	<p><b>III.</b> The Maintenance Director was educated regarding the storage of combustible material in hazardous areas by the Regional Plant Operations Manager.</p> <p>All staff were educated regarding the proper storage of combustible material.</p> <p><b>IV.</b> The Administrator, Housekeeping Supervisor, and Maintenance Director will audit hazardous areas once per month to ensure no combustible material is being stored. The audit findings will be presented to the Quality Assurance Performance Improvement Committee.</p>	10/23/15

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K 029	Continued From page 5 (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction. (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure automatic sprinkler systems were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty-four (24) residents, staff, and visitors.  The findings include:  Observation on 09/24/15 at 10:33 AM with the	K 062	I. The sprinkler head that was being obstructed by a light fixture, next to room 36, was moved by a licensed contractor.  II. All sprinkler heads were inspected to ensure no other light fixtures or any other objects were obstructing any other sprinkler heads.	

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K 062	<p>Continued From page 6</p> <p>Maintenance Director reveled an automatic sprinkler head next to resident room 36 was obstructed by a light fixture which was located near the sprinkler head. Interview with the Maintenance Director revealed he had not noticed the automatic sprinkler head was obstructed by being located close to the light fixture.</p> <p>Reference: NFPA 13 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p>	K 062	<p><b>III.</b> The Maintenance Supervisor was educated by the Regional Director of Plant Operations to audit all sprinkler heads to ensure no objects are obstructing the sprinkler heads.</p> <p>All staff were educated to maintain the space around the sprinkler heads to prevent any obstructions to the sprinkler heads, such as stored items on shelving.</p> <p><b>IV.</b> The Administrator and Maintenance Supervisor are inspecting 20 sprinkler heads within the facility each month to ensure no obstructions exist. The findings of these audits will be presented in the Quality Assurance Performance Improvement meetings each month.</p>	10/23/15