

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

PRINTED: 10/31/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 11/08/2013
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NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345
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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}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/08/13 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

DEPARTMENT OF HEALTH SERVICES  
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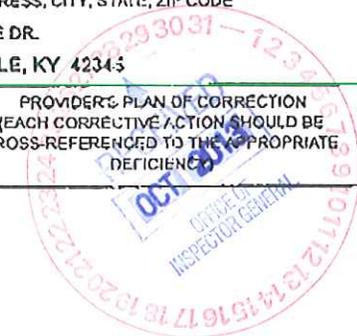
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NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42343
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F 000	INITIAL COMMENTS  A standard recertification survey was conducted on 10/02/13 through 10/04/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E."  F 226 483.13(c) DEVELOP/IMPLEMENT SS-D ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's investigation and policy/procedure, it was determined the facility failed to implement written policies and procedures that prohibit abuse. The facility failed to report an allegation of abuse and the findings of their investigation to the appropriate state agency.  The findings include:  Review of the Abuse/Neglect policy and procedure, undated, revealed the Administrator, Director of Nursing (DON), or Designee would be notified immediately of any incident alleging abuse, neglect, mistreatment or theft. All alleged violations would be reported to the Ombudsman, Adult Protective Services (APS), and Division of Licensing and Regulation within twenty-four (24) hours with the results of the investigation to be reported to appropriate agencies aforementioned	F 000		
		F 226	What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  The alleged incident revealed no harm occurred with a female 104-year-old resident in this facility. The Director of Nurses submitted the allegation of abuse investigation to the state agency representative on 10/04/13 and it was found unsubstantiated.  How will this facility identify other residents having the potential to be affected by the same deficient practice?  All residents had the potential to be affected by the deficient practice.	10/08/13



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

TITLE

(X6) DATE

*[Handwritten Signature]*

*Adm*

*10-28-13*

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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<p>F 226</p> <p>F 371 SS=E</p>	<p>Continued From page 1 within five working days of the incident.</p> <p>Review of the In-house investigation, dated 09/12/13, revealed APS reported an allegation of abuse to the facility, on 09/12/13. It was alleged that a female resident, 104 years old, was receiving a bath stating the water was "too hot." The staff member continued with the shower, per the allegation. The investigation revealed the facility unsubstantiated the allegation; however, there was no evidence the facility had reported the allegation to the State agency.</p> <p>Interview with the Director of Nursing, (DON), on 10/04/13 at 10:00 AM, revealed she was not aware to report the allegation to the State agency, as APS had already completed an investigation.</p> <p>Interview with the Administrator, on 10/04/13 at 11:15 PM, revealed the allegation was unsubstantiated by APS and the facility. He did not know it was required to report the allegation to the State agency as there was "nothing to report."</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</p>	<p>F 226</p>	<p>What measures have been put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Quality Assurance Coordinator provided education of the F 226 law and the interpretive guidelines to the Administrator and the Director of Nurses on 10/04/13. The facility shall report all alleged violations, even those APS reports that are found unsubstantiated, and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation.</p> <p>How will this facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Administrator shall monitor the performance of the Director of Nursing weekly to ensure that all alleged violations and all substantiated incidents are reported according to the policy and procedure of the facility. This monitoring will be documented along with the Safety Team report to the Quality Assurance Team weekly for one year. Alleged compliance date is 10/07/13.</p>	
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NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
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F 371	<p>Continued From page 2</p> <p>by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to store food in the freezer/refrigerator under sanitary conditions.</p> <p>The findings include:</p> <p>Review of the Leftover Food Usage policy/procedure, dated 09/27/13, revealed to store all ready-to-eat foods that were prepped in-house for a maximum of three (3) days. After 3 days, the food must be thrown out to prevent bacteria from growing to unsafe levels.</p> <p>Observation in the kitchen, on 10/02/13 at 9:30 AM, revealed the following:</p> <ol style="list-style-type: none"> <li>One-half (1/2) package of hot dogs in the freezer, undated and unsealed, with a thick layer of ice noted in the package</li> <li>(1) cottage cheese container, labeled "roast" with a date of 09/18/13</li> </ol> <p>Interview with the Dietary Manager, on 10/02/13 at 9:45 AM, revealed food could be stored in the refrigerator for three days, then should be discarded. Freezer items should be wrapped in freezer bags and dated immediately after opening.</p> <p>Interview with the Administrator, on 10/04/13 at 11:15 AM, revealed he expected staff to follow the policy related to the storage of food in the kitchen. He revealed it was a group effort between the dietary manager and dietary staff to monitor for compliance.</p>	F 371	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Dietary covered and dated all opened containers or leftover food items on 10/02/13.</p> <p>How will this facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents had the potential to be affected by the deficient practice.</p> <p>What measures have been put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Food Service Supervisor shall monitor weekly dietary services including food preparation and storage. All opened containers or leftover food items shall be covered and dated when refrigerated. The Dietary Consultant, Shirley Harper, provided In-Service Education on "Proper Food Preparation and Storage" on 10/03/13.</p>	10/08/13

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F 463 F 463 SS=D	Continued From page 3 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure each bathroom available for resident use was equipped to receive resident calls through a communication system.  The findings include:  Observation, on 10/03/13 at 10:45 AM, revealed one bathroom on the therapy hall and two bathrooms in the office lobby without an emergency communication system in place. Both bathrooms were unlocked and available for resident use.  Interview with the Director of Nursing (DON), on 10/04/13 at 10:00 AM, verified ambulatory residents used the bathrooms in the office lobby area.  Interview with the Physical Therapy Assistant, on 10/04/13 at 11:05 AM, verified residents used the bathroom located on the therapy hall.  Interview with the Administrator, on 10/04/13 at 11:15 AM, revealed the bathroom on the therapy hall was utilized by residents, however, it was rare for a resident to use the office lobby bathrooms.	F 463	How will this facility plan to monitor its performance to ensure that solutions are sustained?  The Food Service Supervisor shall document and report to the Quality Assurance Team weekly checks of the proper storage of food items. Alleged date of compliance is 10/07/13.  What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  The facility is installing an Audio/Visual communication emergency system in the three bathrooms identified. The projected date of compliance is 11/07/13.  How will this facility identify other residents having the potential to be affected by the same deficient practice?  All residents had the potential to be affected by the deficient practice.	11/08/13

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			<p>What measures have been put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The facility is installing a communication emergency system in the three bathrooms identified. An assessment of the entire building for other resident rooms, resident toilet and resident bathing facilities was made to assure that all have the available resources of a call system in place.</p> <p>How will this facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>The Safety Team shall monitor the Environmental Safety Supervisor's weekly checks of the Nurse Call-light system to ensure that all resident rooms, resident toilets and resident bathroom facilities have available use of a communication emergency system. The alleged completion date for compliance is 11/07/13.</p>		

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{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/08/13 as alleged.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. 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: 1965.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1965, with 35 smoke detectors and 1 heat detector.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965 and upgraded in 2003.</p> <p>GENERATOR: Type II generator installed in 2008. Fuel source is Diesel</p> <p>A standard Life Safety Code survey was conducted on 10/02/2013. Belle Meade Home was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty-Two (62) beds with a census of Fifty-One (51) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>Preparation and/or execution of the Plan of Correction does not constitute admission or agreement to the alleged cited deficiencies.</p> <p>Belle Meade Home submits this Plan of Correction as evidence of adherence to state and federal requirements for licensure and participation in the Medicare and Medicaid programs.</p> <p>This document is not intended to waive any defense, legal or equitable, in administrative, civil, or criminal proceedings.</p> <p>Sprinkler System installed in 1980</p>	
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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Adm (X5) DATE 10-28-13

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NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. 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)
K 018	<p>Continued From page 2</p> <p>visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-One (51) on the day of the survey. The facility failed to ensure seven (7) corridor doors to the resident rooms were latching properly.</p> <p>The findings include:</p> <p>Observations, on 10/02/13 between 1:00 PM and 3:30 PM with the Maintenance Personnel, revealed the corridor doors to rooms 314, 226, 300, 326, 312, 218, and 204 would not latch properly.</p> <p>Interview, on 10/02/13 between 1:00 PM and 3:30 PM with the Maintenance Personnel, revealed he was unaware these doors were not latching properly.</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 13/4-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.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or</p>	K 018	<p>How will this facility plan to monitor its performance to ensure that solutions are maintained?</p> <p>The Safety Team shall monitor the Environmental Safety Supervisor for six months and resume yearly review after no further deficient practices are identified. The Environmental Safety Supervisor shall complete a weekly safety check of all door latches and maintain them in compliance to the regulated standard. The Safety Team shall report to the Quality Assurance Team quarterly. The facility is alleging a compliance date of 11/07/13.</p>

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NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42344
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K 018	Continued From page 3 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.  19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is 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. Roter latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/2-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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross	K 027	K 027 What Corrective action will be accomplished for those residents found to have been affected by the deficient practice?  No residents were affected by the deficient practice. The cross-corridor doors located at room #300, room #218 and room #200 were repaired on 10/24/13.  How will this facility identify other residents having the potential to be affected by the same deficient practices?  All residents had the potential to be affected by the deficient practice.	10/29/13

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K 027	Continued From page 4  -corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-One (51) on the day of the survey. The facility failed to ensure three (3) doors in the smoke barriers had a gap less than 1/8 inch where the doors meet.  The findings include:  Observation, on 10/02/13 between 1:00 PM and 3:30 PM with the Maintenance Personnel, revealed the cross-corridor doors located at room #300, room 218 and 200 would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke.  Interview, on 10/02/13 between 1:00 PM and 3:30 PM with the Maintenance Personnel, revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position.  Reference: NFPA 101 (2000 edition)  8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.  Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7	K 027	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  Smoke barrier doors closed allowing a gap of less than 1/8 inch where the doors meet added to the weekly Environmental Safety report.  How will this facility plan to monitor its performance to ensure that solutions are maintained?  The Safety Team shall monitor the Environmental Safety Supervisor for six months and resume yearly evaluations after no further deficient practices are identified. The Environmental Safety Supervisor shall complete a weekly Safety Check of all smoke barrier devices, including, but not limited to, the cross-corridor doors and maintain them in compliance with the regulated standard. The Safety Team shall report to the Quality Assurance Team quarterly. The facility is alleging compliance on 10/28/13.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(02) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(03) DATE SURVEY COMPLETED  10/02/2013
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
(04) 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)	(05) COMPLETION DATE	
K 027	Continued From page 5 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027			
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on interview and facility record review, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-One (51) on the day of the survey. The facility failed to ensure they conducted an annual emergency lighting testing for the minimum requirement of at least once annually for 1-1/2 hour duration and 30 seconds monthly.  The findings include:  Record review, on 10/02/13 at 1:40 PM with the Maintenance Personnel, revealed that the emergency lights, with battery backup, located throughout the facility had not been tested for 1-1/2 hours within the last year and no documentation for 30 second monthly testing.  Interview, on 10/02/13 at 1:40 PM with the Maintenance Personnel, revealed he was unaware the lighting had to be tested annually for 1-1/2 hours and documentation kept for the	K 046	K 046 What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  No residents were affected by the deficient practice. The emergency lights test of 30 seconds and 1 ½ hour testing where performed and documented on 11/07/13.  How will this facility identify other residents having the potential to be affected by the same deficient practices?  All residents had the potential to be affected by the deficient practice.  What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  Monthly testing of the emergency lights, with battery backup, located throughout the facility shall be tested for 1 ½ hours yearly and for 30 seconds monthly and documentation shall be kept by the Environmental Safety Supervisor and added to the first week of the month Environmental Safety Rounds report.	11/08/13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. 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
K 046	<p>Continued From page 6</p> <p>monthly 30 second checks.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual</p>	K 046	<p>How will this facility plan to monitor its performance to ensure that solutions are maintained?</p> <p>The Safety Team shall monitor the Environmental Safety Supervisor's maintenance and documentation of emergency light testing according to the regulated standard. The Safety Team shall report to the Quality Assurance Team quarterly. The facility is alleging compliance on 11/07/13.</p>	

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NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345
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K 046	Continued From page 7 inspection is performed at 30-day intervals.	K 046		
K 064 SS=F	NFFA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFFA 10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the installed fire extinguishers in accordance with NFFA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-One (51) on the day of the survey. The facility failed to ensure the fire extinguishers in the facility had their six (6) year maintenance.  The findings include:  Observation, on 10/02/13 between 1:00 PM and 3:30 PM with the Maintenance Personnel, revealed a fire extinguisher in the laundry, the area behind the small dryer, rehab hall and the office hall with the last six (6) year maintenance performed in 2005.  Interview, on 10/02/13 between 1:00 PM and 3:30 PM with the Maintenance Personnel, revealed the facility was not aware the portable fire extinguishers had not been serviced properly, by their extinguisher service company.	K 064	K 064  What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  No residents were affected by the deficient practice. The fire extinguishers in the laundry, the area behind the small dryer, rehab hall and the office hall shall receive the six (6) year maintenance or be replaced by 11/07/13.  How will this facility identify other residents having the potential to be affected by the same deficient practices?  All residents had the potential to be affected by the deficient practice.  What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  All Fire extinguishers checked by the Environmental Safety Supervisor weekly. The six (6) year maintenance date added to the Environmental quarterly report to the Quality Assurance team.	11/08/13

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NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345
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K 064	<p>Continued From page 3</p> <p>Reference: NFPA 10 (1998 ed.) Actual NFPA Standard: NFPA 10, 4-4.3*. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.</p> <p>Exception: Non-rechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture.</p> <p>Non-rechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3.</p> <p>Actual NFPA Standard: NFPA 10, 4-4.4*. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service.</p> <p>Actual NFPA Standard: NFPA 10, 4-4.4.1*. Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. by 3 1/2 in. (5.1 cm 8.9 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information:</p> <p>(a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch</p> <p>(b) Name or initials of person performing the</p>	K 064	<p>How will this facility plan to monitor its performance to ensure that solutions are maintained?</p> <p>The Safety Team shall monitor the Environmental Safety Supervisor's weekly reports of the fire extinguisher maintenance and report to the Quality Assurance Team quarterly. This facility is alleging compliance date of 11/07/13.</p>	
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K 054	Continued From page 9 maintenance and name of agency performing the maintenance Actual NFPA Standard: NFPA 10, 4-4.4.2*. Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999. Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.	K 064		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  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 NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, sixteen (16) residents, staff and visitors. The	K 147	K147 What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  No resident was affected by the deficient practice. The regulated standard space provided for the electrical panel in the Nurses Station was cleared on 11/07/13.  How will this facility identify other residents having the potential to be affected by the same deficient practices?  All residents had the potential to be affected by the deficient practice.	11/08/13

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K 147 Continued From page 10

facility is certified for Sixty-Two (62) beds with a census of Fifty-One (51) on the day of the survey. The facility failed to ensure an electrical panel maintained three (3) feet of clearance.

The findings include:

Observations, on 10/02/13 at 1:40 PM with the Maintenance Personnel, revealed the electrical panel in the IC nurses' station had storage within 3 feet of the electrical panels. The panel was blocked by cabinets with nursing supplies and a copy machine.

Interview, on 10/02/13 at 1:40 PM with the Maintenance Personnel, revealed he was aware there could not be storage within 3 feet of electrical panels due to the previous survey but this panel was not mentioned on the previous survey.

Reference: NFPA 70 (1999 edition)

110-26. Spaces

110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.

(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or

K 147 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

Electrical panels added to the weekly Environmental Safety Rounds. An In-Service was provided to Licensed Nurse personnel entitled "Regulated Space" by the Environmental Safety Supervisor on 10/28/13 to ensure the 3 foot clearance space of the electrical panel in the Nurse Station is maintained at all times.

How will this facility plan to monitor its performance to ensure that solutions are maintained?  
The Safety Team shall monitor the weekly Environmental Safety Rounds report completed by the Environmental Safety Supervisor. The Safety Team shall report to the Quality Assurance team quarterly. Alleged compliance date 11/07/13.

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K 147	<p>Continued From page 11</p> <p>permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td colspan="2">1 m (3½ ft)</td> </tr> <tr> <td></td> <td></td> <td colspan="2">1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows:</p> <p>Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts.</p> <p>Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded.</p> <p>Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)				1.2 m (4 ft)		K 147	
Nominal Voltage to Ground	Minimum Clear Distance																						
Condition 1	Condition 2	Condition 3																					
0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)																				
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K 147 Continued From page 12  
 required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.  
 (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at: not greater than 30 volts rms, 42 volts peak, or 50 volts dc.  
 (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation.  
 (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.  
 (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment.  
 (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be

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K 147	<p>Continued From page 13</p> <p>suitably guarded.</p> <p>(C) Entrance to Working Space.</p> <p>(1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment.</p> <p>(2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met.</p> <p>(a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted.</p> <p>(a) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition.</p> <p>(D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1). Exception No. 1, for switched receptacles. In electrical equipment</p>	K 147		
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K 147	Continued From page 14 rooms, the illumination shall not be controlled by automatic means only	K 147		
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