

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

PRINTED: 11/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185435	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2014
NAME OF PROVIDER OR SUPPLIER MAGNOLIA VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1381 CAMPBELL LANE BOWLING GREEN, KY 42104	
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F 000	INITIAL COMMENTS A Recertification Survey was conducted on 11/05/14 through 11/07/14 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "E".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Magnolia Village Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 248 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Health Care Supply Company electronic mail (e-mail), it was determined the facility failed to provide cords for five (5) bathroom call lights and the failed to provide call light cords that would be accessible to a resident if on the floor for twenty-four (24) our of twenty-six (26) resident bathrooms. The findings include: Observation on 11/04/14 from 10:00 AM through 10:30 AM, during the initial facility tour, revealed short call light cords in the bathrooms of eight (8) out of nine (9) rooms. Call light cords were of inconsistent lengths and greater than 4 (four) to 6 (six) inches from the bathroom floor.	F 246	<u>F 246</u> The Maintenance Director replaced all call cords that were missing and repaired all call cords so that no cord was greater than 4 to 6 inches from the floor as identified in the 2567 on 11/24/14. Residents of the facility have the potential to be affected. The maintenance director completed an audit on 11/7/17 on all resident bathrooms to ensure that the cord was present and that the call cord was no greater than 4 to 6 inches from the floor. All identified concerns were corrected by the maintenance director on 11/24/14.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: Administrator (X6) DATE: 12/3/14

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 246	Continued From page 1 Observation, on 11/06/14 at 1:40 PM with Housekeeping Supervisor, revealed every bathroom has two (2) call light panels, one (1) near the shower area and one (1) near the commode. The Housekeeping Supervisor stated she was unsure if there was a specific length for the bathroom call light cords. Further observation revealed commode call light cords were missing in rooms: #332, #336, #337, #338, and 339 and call light cords were greater than 4 (four) to 6 (six) inches from the bathroom floor in rooms: #101, #102, #103, #104, #106, #107, #108, #109, #111, #222, #223, #224, #225, #226, #227, #228, #229, #330, #333, #334, #335, and #340. Interview, on 11/06/14 at 1:43 PM with Certified Nurses Aide (CNA) #1, revealed an unsampled resident who resided in 336-B, ambulated to the bathroom alone. She stated she was not sure if the resident would be able to push the call light panel button if he/she were not seated on the commode. Interview, on 11/06/14 at 1:45 PM with Certified Nurses Aide (CNA) #2, revealed an unsampled resident who resided in 338-A, occasionally ambulated to the bathroom alone. She stated the resident would push the button on the call light panel when he/she needed assistance. CNA #2 stated she was not sure if the resident in 338-A would be able to push the call light panel button if she/he were not seated on the commode. Interview, on 11/06/14 at 2:30 PM with unsampled resident who resided in 338-A, revealed he/she occasionally ambulated to the bathroom alone. He/she stated the call light panel near the commode did not have a call light cord attached.	F 246	Administrator re-educated all staff on the components of the call system specifically the cord and on the process to follow upon identifying a missing or inadequate component of the system on 11/24/14. Posttest was completed to validate understanding and graded by the Director of Nurses. The Maintenance Director will conduct facility rounds weekly for four weeks, then monthly to assess that the components of the call system are present and functioning. The Maintenance Director will report findings to the Performance Improvement Committee monthly for three months then quarterly for further recommendations. The Performance Improvement Committee consists of Administrator, Director of Nursing, Medical Director, Social Services Director, Admission Director, Dietary Director and Maintenance Director. Completion Date:	11/25/14	

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F 246	Continued From page 2 Further review revealed he/she could press the call light panel button if he/she needed assistance while seated on the commode but he/she would not be able to reach the button if he/she fell in the bathroom. Interview, on 11/06/14 at 1:48 PM with Housekeeping Supervisor, revealed the unsampled resident who resided in 339-B, ambulated to the bathroom alone. She stated the resident probably would not be able to reach the call light panel button if she fell or was not seated on the commode. Further interview revealed the Housekeeping Supervisor was unsure if bathroom call light cords should always be replaced. Interview, on 11/06/14 at 2:15 PM with Maintenance Director, revealed bathroom call light cords are "about six (6) feet long" when received from the Healthcare Supply Company. He stated maintenance checked one (1) hallway on Friday each week and replaced missing cords. The Maintenance Director said there were two (2) residents who wander and pull cords out of the call cord plates. He stated maintenance shortened call light cords, when replaced, to hang below the bathroom handrail to prevent a choking hazard. Review of an electronic mail (e-mail), dated 11/06/14 at 8:15 AM from the Healthcare Supply Company, revealed they "normally recommended bathroom call light cords hang four (4) to six (6) inches from the floor but it depended on the State Inspector. They may recommend a different length."	F 246			
F 285	483.20(m), 483.20(e) PASRR REQUIREMENTS	F 285			

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F 285 SS=E	Continued From page 3 FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental	F 285	<u>F 285</u> The 15 residents identified in the 2567 with a late or missing PASSR was completed by the Social Services Director on 11/6/14. Residents of the facility have the potential to be affected. An audit was conducted on all resident records on 11/6/14 by the Social Services Director with corrective action completed on 11/6/14 by the Social Services Director. Re-education was provided to the Admission Director and Social Services Director by the Administrator on 11/6/14 on the process to follow for PASSR completion. A posttest was completed to validate understanding and reviewed by the Administrator. The Social Services Director will conduct audits weekly for four weeks on all new admissions and three audits per month for an additional two months to monitor the compliance of the PASSR. The Social Services Director will report results to the Performance Improvement Committee monthly for three months and then quarterly for further recommendations. The Performance Improvement Committee consists of Administrator, Director of Nursing, Medical Director, Social Services Director, Admission Director, Dietary Director and Maintenance Director. Completion Date	11/25/14	

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F 285	<p>Continued From page 4</p> <p>illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to conduct pre-admission screening to evaluate the level of services required for fifteen (15) unsampled residents(Residents A-O), upon admission. The facility also failed to complete the pre-admission screening (PASRR) according to policy guideline time frame for one (1) of fifteen (15) sampled residents(Resident #10).</p> <p>The findings include:</p> <p>Review of the facility's Pre-Admission Screening Mental Health/Mental Retardation policy, last revised 03/01/14, revealed facility staff will assure that all Mentally Ill (MI) and/or Intellectual/Developmental Disability(ID/DD) residents receive appropriate pre-admission screenings according to federal and/or state regulations.</p> <p>Record review revealed the facility admitted Resident #10 on 08/05/14 with diagnoses which included Dementia with behavioral disturbances, Delusional Disorder, Unspecified Psychosis, Cognitive Communication Deficit, and Altered Mental Status.</p> <p>Further record review revealed there was no evidence the facility had conducted the required</p>	F 285		

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F 285	<p>Continued From page 5</p> <p>Level One (1) Pre-admission Screening to determine if placement in the facility was appropriate. The PASRR was completed (as signed) on 08/22/14.</p> <p>Interview with Admissions Director, on 11/06/14 at 1:57 PM, revealed all Medicaid residents have to have PASRR done and it can be done after the resident was admitted to facility. She stated the PASRR was not required on all admissions as it depends on their diagnosis. She revealed that a Level One PASRR was completed after a resident was admitted to the facility but she was not sure of the time frame for when Level One PASRR was to be completed after admission. She stated she can complete the PASR or the transferring facility can complete PASRR. She revealed all the facility's beds were Certified.</p> <p>Interview with Director of Nursing (DON), on 11/07/14 at 9:10 AM, revealed the facility did a 100% Chart Audit for the completion of PASRR'S. She stated the chart audit revealed Level One PASRR'S had not been completed on fifteen(15) residents (Residents A-O).</p>	F 285		

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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: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with five (5) heat detectors and sixty-one (61) smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/05/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of fifty-six (56) 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 Fire)</p>	K 000		

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

[Handwritten Signature]

TITLE
Administrator

(X8) DATE
11/25/14

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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K 000	Continued From page 1	K 000		
K 066 SS=D	<p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for the residents was properly equipped for safe smoking, in accordance with the National Fire</p>	<p><u>KO66</u></p> <p>On 11/10/14 The Maintenance Director placed a fire extinguisher in the designated outdoor smoking area.</p> <p>Administrator completed an audit of the designated outdoor smoking area on 11/10/14 and identified we were in compliance with the standards for the designated outdoor smoking area for residents was properly equipped for safe smoking in compliance with the NFPA standards.</p> <p>The Maintenance Director was re-educated by the Administrator on 11/17/14 on the standards for the designated residents smoking area to comply with the NFPA standards.</p> <p>The Maintenance Director will conduct monthly audits of the smoking area to ensure that the fire extinguisher is present according to the NFPA standards for three months then quarterly. The Maintenance Director will report findings to the performance improvement committee. The Performance Improvement Committee consists of Administrator, Director of Nursing, Medical Director, Social Services Director, Admission Director, Dietary Director and Maintenance Director.</p> <p>Completion Date</p>	11/25/14	

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K 066	<p>Continued From page 2</p> <p>Protection Association (NFPA) standards. The deficiency had the potential to affect residents using the smoking area. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-six (56).</p> <p>The findings include:</p> <p>Observation, on 11/05/14 at 3:12 PM, with the Maintenance Director revealed the designated outdoor smoking area for residents did not have a fire extinguisher installed that was readily available.</p> <p>Interview, on 11/05/14 at 3:13 PM, with the Maintenance Director revealed he was not aware of the requirements for smoking areas.</p> <p>The census of fifty-six (56) was verified by the Administrator on 11/05/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/05/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the</p>	K 066		

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K 066	Continued From page 3 international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066		