

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

PRINTED: 03/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/01/2014
NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS Based on implementation of the acceptable POC, the facility was deemed to be in compliance, 04/01/14 as alleged.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104	
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F 000	INITIAL COMMENTS A Recertification Survey was conducted on 02/26/14 through 02/28/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "D".	F 000	Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy and procedure review, it was determined the facility failed to ensure adequate oxygenation during tracheostomy (trach) care and suctioning for one (1) of twenty-four (24) sampled residents (Resident #12). Observation of tracheostomy care/suctioning for Resident #12 revealed the licensed staff failed to provide oxygen (O2) before and after suctioning and during trach care. The findings include:	F 328	Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.	



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

TITLE

(X6) DATE

[Signature] *[Signature]* *3/20/14*

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 328	<p>Continued From page 1</p> <p>Review of the facility's policy/procedure titled, "Tracheostomy Suctioning", not dated, and "Tracheal Suctioning from Nursing Procedure Manual", (Version date: April 2013), revealed staff should pre-oxygenate patient to prevent hypoxia prior to suctioning and after suctioning, supplement oxygen for several breaths.</p> <p>Record review revealed the facility admitted Resident #12 on 07/20/13 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension, Pneumonia, Depression, Dyslipidemia, Expressive Aphasia, Dysphagia, Diastolic Dysfunction, and Respiratory Failure requiring tracheostomy tube placement. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/03/14, revealed the facility assessed Resident #12's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of "2".</p> <p>Review of a physician order, dated 02/01/14, revealed the physician ordered O2 at three (3) liters per minute (lpm.) continuous with 28% humidity via trach and suctioning every shift and as needed.</p> <p>Observation, on 02/27/14 at 4:05 PM of Licensed Practical Nurse (LPN) #2 performing trach care, revealed the O2 trach mask was to the right of the tracheostomy (trach) tube on the side of the resident's neck upon entry to the room and not over the resident's trach. The LPN proceeded to prepare to provide trach care and suctioning without reapplying the resident's O2. At 4:10 PM, the LPN noted there was no face mask in the cabinet and left the room to get a mask. LPN #2 reentered the room and applied a gown, gloves and mask. She opened the trach care kit and</p>	F 328	<p>Tag F328</p> <p>To assist with compliance with facility policy/procedure for oxygenation of resident #12 during tracheostomy care, tracheostomy care for resident #12 will be monitored (by Nursing Unit Coordinators/DON/ADON/ Staff Development Coordinator) weekly for one month, then bi-monthly for one month, then monthly for three months starting March 24, 2014. Upon identification of any potential concerns regarding oxygenation during tracheostomy care monitoring, the Nursing Unit Coordinators/DON/ADON/ Staff Development Coordinator will take follow up action as necessary.</p> <p>Resident #12 is only resident in facility with tracheostomy.</p> <p>The Staff Development Coordinator will re-in-service licensed nursing staff on oxygenation during tracheostomy care per facility policy and procedure. This re-in servicing was initiated on March 12, 2014 with expected completion date of April 1, 2014. Staff Development Coordinator will then provide yearly in-servicing of licensed nursing staff regarding oxygenation policy and procedure during tracheostomy care.</p>		

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F 328	<p>Continued From page 2</p> <p>placed the contents on the bedside table and removed her gloves. LPN #2 applied the sterile gloves, opened a container of peroxide and a container of sterile water and poured them into the sterile basin provided in the trach care kit. LPN #2 then explained the procedure to the resident. The LPN made a sterile drape, placed it over the resident's chest and covered the oxygen mask during trach care. Resident #12 remained without supplemental oxygen throughout the trach care procedure.</p> <p>In addition, further observation revealed the LPN proceeded to provide suctioning. The LPN inserted the catheter into the trach tube for suctioning making four (4) passes into the airway without waiting to allow the resident to recover. The LPN failed to ensure the resident was given oxygen prior to and after suctioning to prevent hypoxia. The LPN applied the finger pulse oximeter to Resident #12's right hand and the resident's oxygen saturation level (SpO2) was 90% after completion of the suctioning and increased to 93% on room air. At 4:40 PM, the resident's oxygen was reapplied per humidified trach mask at three (3) lpm. The LPN failed to ensure the resident received oxygen for a total of thirty-five minutes.</p> <p>Interview with LPN #2, on 2/27/14 at 4:45 PM, revealed Resident #12 often moves around the bed and pulls off the trach mask. She stated the resident was unable to replace the mask back over the trach due to his/her cognition level. LPN #2 revealed she had worked at the facility for five (5) months and had been a nurse for fifteen (15) years. She stated "when hired I didn't need to be taught how to do trach care and suctioning; I just needed to learn how the facility does it". The LPN</p>	F 328	<p>The result summaries of the tracheostomy monitoring for oxygenation compliance which will be completed by the DON, will be forwarded to the Executive QA Committee monthly for three months for review, identification of trends, for follow-up action as deemed appropriate, and to determine need for and/or frequency of continued monitoring.</p> <p>Date of completion is 4/1/14.</p>	4/1/14	

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F 328	Continued From page 3 stated she should have waited one (1) to one and one-half (1 and 1/2) minutes between the passes of the suctioning catheter and she failed to do this during suctioning of this resident. The LPN revealed it depended on what the resident's SpO2 was, if oxygen should be reapplied between suction passes. The LPN stated the complications of suctioning were a decrease in alertness and orientation, a drop in oxygen level, bleeding, respiratory distress and cardiac arrest. She stated suctioning a resident takes the resident's air away. Interview with the Director of Nursing (DON), Clinical Nurse Consultant, and 200 Hall Unit Coordinator, on 02/28/14 at 12:58 PM, revealed staff should monitor a resident for a change in heart rate, distress, and/or a change in respiratory pattern while conducting trach care and suctioning. They stated the SpO2 monitor should be in place to monitor the SpO2 during these procedures. They revealed thirty five (35) minutes without oxygen would be excessive for a resident that was ordered continuous oxygen.	F 328			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	F431 Storage cabinet was immediately and permanently removed from resident's (#12) room. All resident rooms were immediately inspected by nursing administration and found to be in compliance. Individual storage cabinets for tracheostomy care medications will no longer be placed in resident rooms.		

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F 431	<p>Continued From page 4</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure drugs and biologicals used in the facility were stored appropriately.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 02/28/14 at 12:58 PM, revealed the facility does not have a policy on the storage of biologicals.</p> <p>Observation, on 02/27/14 at 9:04 AM, 9:55 AM and 10:32 AM, revealed there were multiple forms of normal saline and peroxide in an</p>	F 431	<p>All resident rooms will be monitored for regulatory compliance for storage of biologicals (by Nursing Unit Coordinators/DON/ADON/ Staff Development Coordinator/Safety Nurse) weekly for one month, then bi-monthly for one month, then monthly for three months. Upon identification of any potential concerns, the Nursing Unit Coordinators/DON/ADON/ Staff Development Coordinator will take follow up action as necessary.</p> <p>The Staff Development Coordinator began re-in servicing licensed nursing staff regarding the storage of Normal Saline and Peroxide in locked compartments per regulation. This re-in servicing was initiated on March 12, 2014 with expected completion date of April 1, 2014.</p> <p>The result summaries of the building monitoring for biologicals storage will be forwarded by the DON to the Executive QA Committee monthly for three months for review, identification of trends, for follow-up action as deemed appropriate, and to determine need for and/or frequency of continued monitoring</p> <p>Date of completion is 4/1/14.</p>	4/1/14	

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F 431	Continued From page 5 unlocked cabinet over the suction machine in Resident #12's room.	F 431			
F 441 SS=D	Further interview with the DON, on 2/28/14 at 12:58, revealed the normal saline and peroxide should be stored in a locked area. 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.	F 441	Tag F441 To assist with compliance with facility policy in the tracheostomy care of resident #12, tracheostomy care and suctioning for resident #12 will be monitored (by Nursing Unit Coordinators/DON/ADON/ Staff Development Coordinator) for sterile technique compliance per facility protocol weekly for one month, then bi-monthly for one month, then monthly for three months. Upon identification of any potential concerns regarding sterile technique during tracheostomy care, the Nursing Unit Coordinators/DON/ADON/ Staff Development Coordinator will take follow up action as necessary. Resident #12 is only resident in facility with tracheostomy. The Staff Development Coordinator will re-in-service licensed nursing staff on sterile technique during tracheostomy care and suctioning per facility policy and procedure. This re-in servicing was initiated on March 12, 2014 with expected completion date of April 1, 2014. Staff Development Coordinator will provide yearly in-servicing of licensed nursing staff regarding sterile technique policy and procedure during tracheostomy care and suctioning.		

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F 441	Continued From page 6 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to maintain sterile technique during tracheostomy (trach) care and trach suctioning for one (1) of twenty-four (24) sampled residents (Resident #12). The Licensed staff failed to ensure a sterile catheter was placed on a unsterile drape between each pass of suctioning and failed to ensure the inner cannula was cleaned using the sterile hand only. The findings include: Review of the facility's policy/procedure titled, "Aseptic Technique from Infection Control Manual", Version date: 8/2005, revealed utilization of sterile techniques within this facility may include but are not limited to tube insertion or replacement such as urinary catheters, gastrostomy, etc. Record review revealed the facility admitted Resident #12 on 07/20/13 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension, Pneumonia, Depression, Dyslipidemia, Expressive Aphasia, Dysphagia, Diastolic Dysfunction, and Respiratory Failure requiring tracheostomy tube placement. Review of the Quarterly Minimum Data Set (MDS)	F 441	The result summaries of the tracheostomy care monitoring for sterile technique will be completed by the DON and forwarded to the Executive QA Committee monthly for three months for review, identification of trends, for follow-up action as deemed appropriate, and to determine need for and/or frequency of continued monitoring. Date of completion is 4/1/14.	4/1/14	

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F 441	<p>Continued From page 7</p> <p>assessment, dated 01/03/14, revealed the facility assessed Resident #12's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of a "2".</p> <p>Observation of Licensed Practical Nurse (LPN) #1 performing tracheal suctioning for Resident #12, on 02/27/14 at 11:23 AM, revealed LPN #2 applied sterile gloves, placed a catheter around her right hand, turned on the suction machine and obtained suction tubing with the left hand. The trach mask was pulled from over the trach tube and the catheter was inserted without suction applied. The resident spontaneously coughed when suction applied and the catheter retracted pulling the sterile suction catheter across the unsterile trach mask as she withdrew the catheter. The LPN repeated this procedure twice with contact made across the unsterile trach mask each time.</p> <p>Observation of LPN #2 performing trach care for Resident #12, on 02/27/14 at 4:17 PM, the LPN placed a sterile drape over the resident's chest covering the oxygen mask. The LPN proceeded to remove the inner cannula from the trach placing her left hand on the flange of the trach and unlocking the inner cannula with right hand. The LPN placed the inner cannula into the basin of solution and began to clean the catheter using both sterile and unsterile hand. The inner cannula was placed back in the trach. The LPN removed her gown and gloves and placed the dirty items in the trash leaving the unsterile drape over the resident's chest. The LPN again applied gloves and gown to provide suctioning and stated her right hand would be her sterile hand and the left would be her unsterile hand. She placed the catheter in her right sterile hand and utilized the</p>	F 441			

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F 441	<p>Continued From page 8</p> <p>left non-sterile hand to connect the suction tubing. She then proceeded to insert the catheter into the trach tube with the catheter laying on the unsterile drape on the resident's chest. She inserted the catheter with suction applied and a large amount of secretions were aspirated. She cleaned the catheter with sterile water and immediately reinserted the catheter into the trach tube again laying catheter on the unsterile drape. The LPN suctioned a moderate amount of secretions touching resident's chin with the catheter as it came out. She immediately reinserted the catheter and again laid the catheter onto the unsterile drape. The LPN then rinsed the catheter and reinserted it immediately again and for the fourth time laid the catheter on unsterile drape.</p> <p>Interview with LPN #2, on 02/27/14 at 4:45 PM, revealed the drape used for trach care would be considered unsterile after the procedure. She stated the catheter should not have come into contact with the drape during suctioning. The LPN revealed that once the catheter touched the unsterile drape, the catheter would be considered unsterile.</p> <p>Interview with the DON, on 2/28/14 at 12:58 PM, revealed she expected the staff to maintain sterility per policy during trach care and tracheal suctioning. She stated the policy stated staff would maintain sterility with one hand during trach care.</p>	F 441			

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TITLE

(X6) DATE

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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2014
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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>PLAN APPROVAL: 1977</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: Nine (9) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with 2 heat and 52 smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator, installed in October 2010. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/26/14 and 02/27/14. Greenwood Nursing and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred twenty-eight (128) beds with a census of one-hundred twenty-three (123) 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> <p>Deficiencies were cited with the highest deficiency identified at a "E" level.</p>	K 000	<p>Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this</p> <p>Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Archie Williams</i>	TITLE Administrator	(X6) DATE 3/30/14
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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSDALE RD. BOWLING GREEN, KY 42104	
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K 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of nine (9) smoke compartments, fifty-two (52) residents, staff and visitors. The facility is certified for one-hundred twenty-eight (128) beds with a census of one-hundred twenty-three (123) on the day of the survey. The facility failed to ensure three (3) smoke barriers were accessible to determine if they would resist the passage of smoke.</p> <p>The findings include:</p> <p>Observations, on 02/26/14 between 10:05 AM and 12:18 PM with the Maintenance Director, revealed the smoke partitions, extending above the ceiling located at the service halls and the ambulance entrance were inaccessible to inspect for any penetrations.</p>	K 025	<p>K-025</p> <p>There were no specific residents identified.</p> <p>Facility Maintenance staff has installed 5 new attic access doors so that the smoke barriers can be inspected for any penetration. 4 doors were installed in Service area hall and 1 door was installed in 300 hall dining room so that ambulance entrance smoke barrier can be viewed.</p> <p>All other smoke barriers were inspected by the Director of Maintenance and any deficiencies found regarding inaccessible access to smoke barriers have been corrected by facility Maintenance staff. 4/1/14.</p> <p>The Director of Maintenance has been re-inspected by the Administrator on 3/18/14 on the requirement of K025.</p> <p>The Director of Maintenance will complete monthly audits to ensure that all smoke barriers can be visually inspected for penetration.</p> <p>Audit findings will be reviewed monthly with the Administrator, DON and the Medical Director during the Executive Quality Improvement meetings.</p> <p>Completion date 4/1/14</p>	4/1/14

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K 025	<p>Continued From page 2</p> <p>Interview, on 02/26/14 between 10:05 AM and 12:18 PM with the Maintenance Director, revealed he was new to the position and he was unaware that there was not proper access to the smoke barriers.</p> <p>Interview, on 02/27/14 at 09:47 AM with the Administrator, revealed he was unaware there was not proper access to the smoke barriers in the facility. The facility has no policy on the smoke barriers and uses the Life Safety Code book to be in compliance.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for 	K 025		

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K 025	Continued From page 3 the specific purpose.	K 025		
K 029 SS=D	8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose. 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 meet the requirements of Protection of Hazards in accordance with NFPA Standards. The	K 029	There are no specific residents identified in the deficiency. The facility purchased and installed door closers for the Copy room door, Business office door, Classroom door, and Front office storage door. K 029 Facility has removed all paper storage from Dietary office. (Note Copy room has always had door to room and was present on days of survey). The Director of Maintenance and Director of Dietary were in-service on the requirements of K029 by the administrator on 3/18/14. The Director of Maintenance will complete a weekly audit to ensure that dietary office is in compliance with paper storage. Maintenance department will monitor all office area to ensure compliance with paper / file storage. Audit findings will be reviewed monthly with the Administrator the DON and the Medical Director during the Executive Quality Improvement meetings. Date of completion is 4/1/14.	4/1/14

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K 029	<p>Continued From page 4</p> <p>deficiency had the potential to affect three (3) of nine (9) smoke compartments, sixteen (16) residents, staff and visitors. The facility is certified for one-hundred twenty-eight (128) beds with a census of one-hundred twenty-three (123) on the day of the survey. The facility failed to ensure six (6) areas were properly protected due to storage.</p> <p>The findings include:</p> <p>Observations, on 02/26/14 between 12:30 PM and 4:00 PM with the Maintenance Director, revealed dietary office, copy room, business office, front office storage, and the classroom did not have a door closer installed to keep the areas separate from the facility. Further observation revealed no door installed on the dietary office and copy room for separation due to the storage in the rooms.</p> <p>Interview, on 02/26/14 between 12:30 PM and 4:00 PM with the Maintenance Director, revealed he was new to the position and was unaware the areas were considered hazardous storage thus requiring a door and a self-closer.</p> <p>Interview, on 02/27/14 at 09:47 AM with the Administrator, revealed he was aware the amount of combustibles stored in a room determined if it was hazardous or not. The facility has an unwritten policy on storing combustibles in offices and uses the Life Safety code to be in compliance.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K 029		

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K 029	Continued From page 5 19.3.2 Protection from Hazards. 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: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), 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 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit	K 045		

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K 045	<p>Continued From page 6</p> <p>discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of nine (9) smoke compartments, sixty-two (62) residents, staff and visitors. The facility is certified for one-hundred twenty-eight (128) beds with a census of one-hundred twenty-three (123) on the day of the survey. The facility failed to ensure the outside emergency lights had two (2) bulbs at seven (7) exits.</p> <p>The findings include:</p> <p>Observation, on 02/26/14 between 12:30 PM and 4:00 PM with the Maintenance Director, revealed the exterior exits at the rear of 100 hall, dietary exit, 200 dining, 300 B exit, and paramedic door had a single light for illumination of the outside of the exit. Further observation revealed the exterior exit at the 100 hall B exit had no exterior lighting.</p> <p>Interview, on 02/26/14 between 12:30 PM and 4:00 PM with the Maintenance Director, revealed he was new to the position and was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path.</p>	K 045	<p>K045</p> <p>There are no specific residents identified in the deficiency.</p> <p>The facility purchased and installed new LED and double bulb exit lights for the following doors: LED for rear 100 Hall exit, 100 Hall B exit, 200 dining, and 300 exit B. Double bulb for Dietary exit and Paramedic door exit</p> <p>The Director of Maintenance was in-service on the requirements of K045 by the administrator on 3/18/14.</p> <p>The Director of Maintenance will complete a weekly audit to ensure that facility exit doors from the facility has either double bulb or LED lights that are installed and working.</p> <p>Audit findings will be reviewed monthly with the Administrator the DON and the Medical Director during the Executive Quality Improvement meetings.</p> <p>Date of completion is 4/1/14.</p>	4/1/14

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K 045	Continued From page 7 Interview, on 02/27/14 at 09:47 AM with the Administrator, revealed he was aware there was to be exterior lighting at an exit discharge but was unaware there had to be at least two bulbs serving the exit. The facility has no policy on exterior lighting and uses the Life Safety Code to be in compliance. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

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K 051	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one-hundred twenty-eight (128) beds with a census of one-hundred twenty-three (123) on the day of the survey. The facility failed to ensure the one (1) exit had a manual fire alarm pull station located within five (5) feet. The findings include: Observation, on 02/27/14 at 9:40 AM with the Maintenance Director, revealed the exit at 300 hall dining room did not have a manual pull station located within five (5) feet of the exit door. The nearest manual fire pull was located eleven (11) feet from the exit. Interview, on 02/27/14 at 9:40 AM with the Maintenance Director, revealed he was new to the position and was unaware of the maximum distance of a fire pull station from an exit. Interview, on 02/27/14 at 9:47 AM with the Administrator, revealed he was unaware of the	K 051	K051 There are no specific residents identified in the deficiency. The facility contracted with AAA alarms to move the current pulling next in the 300 hall dining room door from 11 feet to with -in 5 feet of the exit door. The Director of Maintenance was in-service on the requirements of K051 by the administrator on 3/18/14. The Director of Maintenance will complete a Monthly audit of all exit doors to ensure that emergency pull stations are with-in 5 feet. Audit findings will be reviewed monthly with the Administrator the DON and the Medical Director during the Executive Quality Improvement meetings. Date of completion is 4/1/14.	4/1/14

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K 051	Continued From page 9 maximum distance for a fire pull to be from an exit. The facility has no policy on exterior lighting and uses the Life Safety code to be in compliance. Reference: NFPA 101 (2000 Edition). 19.3.4.2* Initiation. Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems. Exception No. 1: Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other continuously attended staff location, provided that such manual fire alarm boxes are visible and continuously accessible and that travel distances required by 9.6.2.4 are not exceeded.	K 051		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	K056 There are no specific residents identified in the deficiency. The facility contracted with Stewart Richey Service Group to install additional sprinklers in the following rooms 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 202, and 206. This will ensure sprinkler protection for the opened top closets. These new sprinklers were installed above the closet and over 5 feet away from the current sprinklers. Stewart Richey	

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K 056	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of nine (9) smoke compartments, sixty-two (62) residents, staff and visitors. The facility is certified for one-hundred twenty-eight (128) beds with a census of one-hundred twenty-three (123) on the day of the survey. The facility failed to ensure all closets of the building had proper sprinkler coverage and that sprinkler heads were properly spaced from one another. According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems. The findings include: Observation, on 02/26/14 between 12:30 PM and 4:00 PM with the Maintenance Director, revealed the closets in the resident rooms #101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 202, and 206 did not have sprinkler protection. Further observation revealed the closets were built in the facility with the top of the closet opened up ten (10) inches from the ceiling and the sprinkler in the room was over five (5) feet from the closets. Interview, on 02/26/14 between 12:30 PM and 4:00 PM with the Maintenance Director, revealed he was new to the position and was not aware that the closets listed did not have proper sprinkler protection.	K 056	Service Group removed the following sprinklers that were with-in 6 feet of another sprinkler head. The following locations are: Business office, Front office storage, Clean utility 200 hall, Clean utility 300 hall, Activity office, and Paramedic entrance in corridor. (Facility has no Clean Utility on 100 hall with sprinkler Issues must have been typo for 300 hall) The Director of Maintenance was in-service on the requirements of K0516 by the administrator on 3/18/14. The Director of Maintenance will complete a Monthly audit of all opened top closets to ensure they are protected with sprinklers based on the regulation and will verify that there are no other sprinklers with-in 5 feet of each other in the facility as related to K056 Audit findings will be reviewed monthly with the Administrator the DON and the Medical Director during the Executive Quality Improvement meetings. Date of completion is 4/1/14.	4/1/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104	
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K 056	<p>Continued From page 11</p> <p>Interview, on 02/27/14 at 09:47 AM with the Administrator, revealed he was unaware the closets in the resident rooms were not properly sprinklered. The facility has no policy on sprinkler coverage and uses the Life Safety code to be in compliance. Further interview revealed he attended a training in Louisville where this issue was discussed and believed his facility was in compliance with the code.</p> <p>Observations, on 02/26/14 between 12:30 PM and 4:00 PM with the Maintenance Director, revealed sprinkler heads spaced within 6 feet of another sprinkler head, located in the business office, front office storage, clean utility 200 hall, clean utility 100 hall, activities office, and the paramedic entrance in the corridor. This deficiency would not allow both sprinkler heads to engage at the same heat level.</p> <p>Interview, on 02/26/14 between 12:30 PM and 4:00 PM with the Maintenance Director, revealed he was new to the position and was unaware of the minimum spacing between sprinkler heads.</p> <p>Interview, on 02/27/14 at 09:47 AM with the Administrator, revealed he was aware the sprinklers in the listed areas were within six (6) feet of each other. The Administrator contacted his sprinkler company and had them come to the facility to check on the sprinkler heads. The sprinkler vendor informed the Administrator the sprinkler heads were in compliance. The facility has no policy on sprinkler response times and uses the Life Safety Code to be in compliance.</p> <p>Reference: NFPA 13 (1999 Edition)</p>	K 056		

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K 056	<p>Continued From page 12</p> <p>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference NFPA 13 (1999 edition)</p> <p>8.5.3.4 Minimum Distance Between Sprinklers. 8.5.3.4.1 A minimum distance shall be maintained between sprinklers to prevent operating sprinklers from wetting adjacent sprinklers and to prevent skipping of sprinklers. 8.5.3.4.2 The minimum distance permitted between sprinklers shall comply with the value indicated in the applicable section for each type or style of sprinkler. 8.6.3.4 Minimum Distances Between Sprinklers. 8.6.3.4.1 Unless the requirements of 8.6.3.4.2,</p>	K 056		

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K 056	Continued From page 13 8.6.3.4.3, or 8.6.3.4.4 are met, sprinklers shall be spaced not less than 6 ft (1.8 m) on center. 8.6.3.4.2 Sprinklers shall be permitted to be placed less than 6 ft (1.8 m) on center where the following conditions are satisfied: (1) Baffles shall be installed and located midway between sprinklers and arranged to protect the actuating elements. (2) Baffles shall be of noncombustible or limited-combustible material that will stay in place before and during sprinkler operation. (3) Baffles shall be not less than 8 in. (203 mm) wide and 6 in. (152 mm) high. (4) The tops of baffles shall extend between 2 in. and 3 in. (51 mm and 76 mm) above the deflectors of upright sprinklers. (5) The bottoms of baffles shall extend downward to a level at least even with the deflectors of pendent sprinklers. 8.6.3.4.3 In-rack sprinklers shall be permitted to be placed less than 6 ft (1.8 m) on center. 8.6.3.4.4 Old-style sprinklers protecting fur storage vaults shall be permitted to be placed less than 6 ft (1.8 m) on center. 8.6.4 Deflector Position (Standard Pendent and Upright Spray Sprinklers). 8.6.4.1 Distance Below Ceilings. 8.6.4.1.1 Unobstructed Construction. 8.6.4.1.1.1 Under unobstructed construction, the distance between the sprinkler deflector and the ceiling shall be a minimum of 1 in. (25.4 mm) and a maximum of 12 in. (305 mm) throughout the area of coverage of the sprinkler. 8.6.4.1.1.2 The requirements of 8.6.4.1.1.1 shall not apply where ceiling-type sprinklers (concealed, recessed, and flush types) have the operating element above the ceiling and the deflector located nearer to the ceiling where installed in accordance with their listing.	K 056		

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K 056	Continued From page 14 8.6.4.1.1.3 The requirements of 8.6.4.1.1.1 shall not apply for light and ordinary hazard occupancies with ceilings of noncombustible or limited combustible construction. Where there is a vertical change in ceiling elevation within the area of coverage of the sprinkler creating a distance of more than 36 in. between the upper ceiling and the sprinkler deflector, a vertical plane extending down from the ceiling at the change in elevation shall be considered a wall for the purpose of sprinkler spacing. Where the distance between the upper ceiling and the sprinkler deflector is less than or equal to 36 in., the sprinklers shall be permitted to be spaced as though the ceiling was flat provided the obstruction rules and ceiling pocket rules are observed. (See Figure 8.6.4.1.1.3.)	K 056		