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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. 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
K 050	Continued From page 26 Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 052	Continued From page 27 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, interview and fire alarm test it was determined the facility failed to maintain the fire alarm system per NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff, and visitors. The facility has sixty-six (66) certified beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure manual fire pull stations were not blocked and keys were readily available. The findings include: Observation, on 02/18/14 at 11:10 AM, with the Maintenance Director from a sister facility revealed the manual pull station located by the exit door next to the Therapy Room was blocked by the storage of boxes and construction supplies in the corridor.	K 052	K 052 1. All storage of boxes and construction supplies will be removed and pull stations will be free of all obstructions by 3/28/14. New keys to the manual pull stations will be made and placed on the Maintenance Director or designee key ring and in the fire system box by 3/28/14 2. Daily rounds will be conducted to ensure that compliance is ongoing. 3. Education of staff will be conducted by the Administrator and Maintenance Director that all pull stations need to be clear of obstructions by 3/28/14. 4 The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	3/31/14

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

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K 052	Continued From page 28 Interview, on 02/18/14 between 11:10 AM and 4:30 PM, with the Maintenance Director revealed he was not normally in this building and was not aware they were storing items in the corridor blocking the manual fire pull. Observation of the Fire Alarm Test, on 02/19/14 at 2:00 PM, with the Maintenance Director revealed the facility did not have a key to reset the manual pull stations to discontinue the fire alarm test and reset the fire alarm control panel. The facility had to call a fire alarm contractor to bring out a key. The facility initiated a Fire Watch until the contractor arrived to reset the fire alarm control panel. Interview, on 02/19/14 2:00 PM, with the Maintenance Director revealed he was not aware the Maintenance Director, who was on medical leave, had taken the key home. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy about blocking the fire pull station but was aware they were not to be blocked. Further interview revealed he was not aware the Maintenance Director who was on medical leave, had the key to reset the fire alarm. Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052		
K 054	NFPA 101 LIFE SAFETY CODE STANDARD	K 054		

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K 054 SS=E	Continued From page 29 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure battery smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure that the battery powered smoke detectors located in resident rooms were being properly tested and cleaned. The findings include: Record review, on 02/18/14 at 3:00 PM, with the Administrator revealed the facility failed to provide documentation when the battery smoke detectors were installed. Further review revealed no documented evidence the weekly/monthly testing or cleaning of the battery powered smoke detectors located in the facility. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for testing battery smoke detectors and he was not aware of the testing requirements. Reference: NFPA 72 (1999 ed.)	K 054	K 054 1. All battery operated smoke detectors in the facility have been removed by 3/28/14. 2. The Maintenance Director or Administrator will audit facility to make sure all battery operated smoke detectors have been removed by 3/28/14. 3. Education of staff will be conducted by the Administrator and Maintenance Director or designee on smoke detectors and other fire prevention devices related to NFPA standards by 3/28/14. 4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	3/31/14

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

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K 054	Continued From page 30 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer ' s instructions. The frequency of maintenance shall depend on the type of equipment and the local ambient conditions. Reference: NFPA 101 (2000 ed.) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. 4.6.12.3 Equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. 4.6.12.4 Maintenance and testing shall be under the supervision of a responsible person who shall ensure that testing and maintenance are made at specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction.	K 054		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		

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K 062	Continued From page 31 continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure sprinkler heads located in the attic were free from foreign material, and storage was maintained eighteen (18) inches from a sprinkler head. The findings include: Observations, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed random sprinkler heads located in the attic throughout the facility to be covered in newly installed blow in fiberglass insulation. Further observation revealed there was storage within eighteen (18) inches of a sprinkler head located in the closet of room #15. Interview, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director, revealed he was not aware of the insulation covering the sprinkler heads in the attic or the storage within eighteen (18) inches of the sprinkler head. Interview, on 02/20/14 at 1:30 PM, with the	K 062	1. In Room #15, the item in the closet was removed away from the sprinkler head to maintain eighteen inches from a sprinkler head 2/19/14. The Maintenance Director has air blown the sprinkler heads to clean off fiberglass insulation in the attic by 3/28/14. 2. The Maintenance Director will audit facility to make sure sprinkler heads are clear from any material by 3/28/14. 3. Education by the Administrator and Maintenance Director that sprinkler heads are clear of obstructions by 3/28/14. 4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	3/31/14

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K 062	Continued From page 32 Administrator revealed the facility did not have a policy for cleaning sprinkler heads. Further interview revealed he was aware of the requirements for sprinkler heads; however he was not aware of the insulation covering the sprinkler heads in the attic or the storage within eighteen (18) inches of the sprinkler head. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall	K 062		

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K 062	Continued From page 33 never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062		
K 064 SS=E	NFPA 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, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the installation of portable fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-three (33) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The findings include:	K 064	K 064 1. All storage of boxes and construction supplies will be removed and fire extinguishers will not be obstructed 2/20/14. 2. Fire Extinguisher will be mounted in the back parking lot at our designate smoke area. The fire blanket will be mounted by 3/28/14. New urns and self closing ashtrays have been ordered for the smoking area by 3/28/14. The portable fire extinguisher will mounted by 3/28/14 in the kitchen. 3. Weekly audits will be conducted to ensure that compliance is met by the Maintenance Director or Administrator. Education of the staff will be conducted by the	3/31/14

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K 064	Continued From page 34 Observation, on 02/18/14 at 11:10 AM, with the Maintenance Director from a sister facility revealed the wall mounted, portable fire extinguisher located by the exit door next to the Therapy Room was blocked by the storage of construction tools and supplies being stored in the corridor. Observation, on 02/18/14 between 11:10 AM and 4:00 PM, with the Maintenance Director revealed a smoking area on the Front Porch and another smoking area in the back parking lot. Neither smoking area had a fire extinguisher installed. Observation, on 02/18/14 between 11:10 AM and 4:00 PM, with the Maintenance Director revealed a fire extinguisher sitting on the floor of a hazardous storage room located next to the conference room. Further observation revealed a fire extinguisher sitting on the floor of the Dining Room. Observation, on 02/19/14 at 10:20 AM, with the Maintenance Director revealed the wall mounted, K-class portable fire extinguisher located in the kitchen was blocked by carts. Further observation revealed there was no placard stating that the hood suppression system must be used before the class K fire extinguisher located in the kitchen. This type of extinguisher is used as a secondary measure to the range hood extinguishing system. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed he was not aware the fire extinguishers were sitting on the floor or were blocked. He further stated that was no policy for fire extinguishers but it was part of the monthly rounds to check the fire extinguishers. Further	K 064	Administrator and Maintenance Director that all fire extinguishers are to remain off the floor and mounted correctly by 3/28/14. 4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	

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K 064	Continued From page 35 interview revealed there was a smoking policy that stated all smoking areas would have a fire extinguisher. The Administrator stated he was not aware the smoking areas did not have a fire extinguisher. Reference: NFPA 10 1998 edition 3-7 Fire Extinguisher Size and Placement for Class K Fires. 3-7.1 Fire extinguishers shall be provided for hazards where there is a potential for fires involving combustible cooking media (vegetable or animal oils and fats). 3-7.2 Maximum travel distance shall not exceed 30 ft (9.15 m) from the hazard to the extinguishers. Reference: NFPA 10 1999 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d)* Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place	K 064		

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K 064	Continued From page 36 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	K-066 1. New urns and self closed ashtrays have been ordered for the smoking area 3/13/14. A new metal container with a self-closing cover deice into which ashtrays can be emptied will be readily available to the smoking area by 3/28/14. A fire extinguisher will be mounted in the back parking lot at our designated smoking area. The fire blanket will be mounted by 3/28/14. 2. Weekly audits will be conducted to ensure that compliance is met by the Maintenance Director or Administrator. 3. Education of staff will be conducted by the Administrator or Maintenance Director to follow NFPA standards by 3/2/8/14.	3/31/14
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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.	K 066	4. The Maintenance Director of Administrator will monitor for deficiency findings and report any findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance committee will consist of at a minimum the DON, Administrator, ADON, Dietary Director, Maintenance Director, Social Services Director, and Activities Director with the Medical Director at least Quarterly.	

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K 066	Continued From page 37 (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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 This STANDARD is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays, a fire extinguisher, and a fire blanket. The findings include: Observation, on 02/18/14 at 1:45 PM, with the Maintenance Director from a sister facility revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, fire extinguisher, or a fire blanket located in the designated smoking areas, which	K 066		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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K 066	Continued From page 38 were located at the front entrance, and the rear exit. Interview, on 02/18/14 at 1:44 PM, with the Maintenance Director revealed he was not aware the smoking area did not have the required metal container with a self-closing lid for dumping ashtrays, the fire extinguisher, or the fire blanket. Policy review, on 02/19/14 at 2:38 PM, with the Administrator revealed the smoking policy stated that the facility would provide a metal container with a self-closing lid, a fire extinguisher, and a fire blanket in all designated smoking areas. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed he was not familiar with the smoking policy before 02/19/14. He stated he was not aware the smoking areas did not have the required metal container with a self-closing lid for dumping ashtrays, the fire extinguisher, or the fire blanket. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (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.	K 066		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069	K 069 1. The hood will be cleaned and inspected by outside contractor by 3/28/14 Pull stations have been relocated and will remain free of obstructions. The tables in the kitchen will be	

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	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 069	Continued From page 39 Based on interviews, record review and review of the kitchen hood inspection records, it was determined the facility failed to ensure the kitchen hood system was in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the kitchen hood was cleaned and the hood suppression system was inspected semi-annually. The findings include: Kitchen hood inspection record review, on 02/20/14 at 9:00 AM with the Administrator, revealed the hood inspection had been done; however, the report showed no details of the condition or what was inspected. The report also failed to show when the last hydrostatic test was performed. Further record review revealed the facility failed to produce documentation that the hood had been cleaned within the last year. Interview, on 02/20/14 at 1:30 AM with the Administrator, revealed the facility did not have a policy for Kitchen Hood Inspections. Further interview revealed the Administrator was aware of the testing requirements; however, he was not aware the Kitchen Hood was not being inspected as required. Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using	K 069	removed been removed by 3/28/14. 2. Weekly audits will be conducted to ensure that compliance is met the Maintenance Director or Administrator. 3. Education of the kitchen staff will be conducted by the Administrator and Maintenance Director that the electrical panel should not be blocked by 3/28/14. 4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. . The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	3/31/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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K 069	Continued From page 40 the fire extinguisher. Reference: NFPA 96 (1998 ed.) 8-3 Cleaning. 8-3.1* Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a Extinguishers. properly trained, qualified, and certified company or person acceptable to the authority having jurisdiction in accordance with Table 8-3.1. Table 8-3.1 Exhaust System Inspection Schedule Type or Volume of Cooking Frequency Systems serving solid fuel cooking operations Monthly Systems serving high-volume cooking operations Quarterly such as 24-hour cooking, charbroiling or wok cooking Systems serving moderate-volume cooking Semiannually operations	K 069		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 069	Continued From page 41 Systems serving low-volume cooking operations, such Annually as churches, day camps, seasonal businesses, or senior centers	K 069		
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observations and interview it was determined the facility failed to ensure portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, sixty-six (66) residents, staff, and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The findings include: Observation, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed portable space heaters located in the Therapy Office, Minimum Data Set (MDS) Office, Human Resources Office, and room #11. The facility failed to provide documentation that the heating element in the portable heaters did not exceed 212 degrees Fahrenheit.	K 070	K 070 1. All portable space heaters will removed from Room #11, HR, Therapy office, and MDS office by 3/28/14 2. Daily room rounds will be conducted by Administrator, Director of Nursing, Dietary Manager, Assistant Director of Nursing, Activity Director, Social Services, Housekeeping Director, MDS Manager, Medical Records, Business office Manager, and Maintenance Director. 3.. The Administrator will educate Director of Nursing, Dietary Manager, Assistant Director of Nursing, Activity Director, Social Services, Housekeeping Director, MDS Manager, Medical Records, Business office Manager, and Maintenance Director on space heater	3/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. 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
K 070	Continued From page 42 Interviews, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director revealed he was not aware of the portable heaters in the building. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for the use of portable heaters. Further interview revealed he was aware of the portable heater in room #11 due to the recent cold weather, but he was not aware of the portable heaters located in the offices. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	K-072 1. Obstructions will be removed to have clear egress throughout the building by 3/28/14. Ice carts, medicine carts, trash carts, and rolling carts have assigned locations to have a clear and free egress for residents by 3/28/14. Ice carts are located in the front closet areas. Medicine carts are stored in the A&B Nursing Station areas, trash carts are stored in the shower rooms. 2. Daily room rounds will be conducted by Administrator, DON, ADON, Dietary Director, Activities Director, Social Services Director, Housekeeping Director, MDS Director, Medical Records, Business Office Manager and Maintenance Director. 3. The Administrator will educate Department managers on keeping egress areas clear and free by 3/28/14. 4. The Maintenance Director or Administrator will monitor for deficient findings and report deficient findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the DON, Administrator, ADON, Dietary Director, Maintenance Director, Social Services Director, and Activities Director with the Medical Director at least Quarterly.	3/31/14
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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K 072	Continued From page 43 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments. The findings include: Observations, on 02/18/14 between 11:10 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed the exit by the Therapy Room to have storage of construction tools and supplies consisting of twenty-five (25) cardboard boxes, seven (7) 5-gallon buckets of drywall joint compound, one (1) open 5-gallon bucket of water, drywall tools, and a worker's coat. Further observation revealed a cardboard box, trash carts, a lift, and a medicine cart stored in the A-Hall. Further observation revealed a copy machine, a rolling cart, two (2) ice carts, and a medicine cart stored in the Front Hall; and, an ice cart, medicine cart, chair, and two (2) trash carts stored in the B-Hall. Interview, on 02/18/14 between 11:10 AM and 4:00 PM, with the Maintenance Director revealed he was not aware the items were being stored in the corridors. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed there was no policy for the storage in the corridors, and he was aware the items were being stored in the corridors.	K 072		

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	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 072	Continued From page 44 Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation, interview and policy review it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated. The findings include: Observation, on 02/20/14 at 9:00 AM, with the Administrator revealed the facility failed to document the treatment of non-flame retardant decorations. Policy review, on 02/20/14 at 9:00 AM, with the Administrator revealed the facility had a policy that stated all newly introduced decorations would be treated with a flame retardant and	K 073	K 073 1. Fire retardant was ordered on 3/12/14. 2. Weekly audits will be conducted to ensure that compliance of NFPA standards of application of fire retardant is being met. 3. The Maintenance Director or Administrator will conduct room rounds to treat any decorations and documentation will be reviewed monthly for three months and then quarterly. Any new admissions will have all identified articles treated with fire retardant within 72 hrs of admission by 3/28/14. 4 The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary	3/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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K 073	Continued From page 45 documentation would be kept. Interview, on 02/20/14 at 9:00 AM, with the Administrator revealed he was not aware the documentation had not been kept for treating decorations with a flame retardant. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-three (33) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The findings include: Observation, on 02/18/14 at 11:12 AM, with the Maintenance Director from a sister facility revealed a door wedge holding the Therapy Room door open to the corridor. Further	K 130	K 130 1. The dryer will be cleaned and clear of all lint by Maintenance Director by 3/28/14 The Therapy door wedge was removed 3/10/14. A magnet release lock for the therapy door will be installed by 3/28/14 The slide lock will be removed by 3/28/14. 2. Weekly audits will be conducted on dryers for lint removal and no slide locks are on any door by the Maintenance Director. 3. The Maintenance Director will document any deficiencies. This will be reviewed monthly for three months and then quarterly. 4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality	3/31/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. 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
K 130	Continued From page 46 observation revealed a book-end and paint can holding a door to a hazardous room located in the A-Hall next to the Conference Room. Interview, on 02/18/14 at 11:12 AM, with the Maintenance Director revealed he was not aware they were holding doors open with wedges and paint cans. Observation, on 02/19/14 at 9:38 AM, with the Maintenance Director revealed an unapproved lock [slide-bolt type] was installed on the egress side of the door to the Business Office. Interview, on 02/19/14 at 9:38 AM, with the Maintenance Director revealed he was aware slide bolt locks were not approved; however, he was not aware the slide bolt lock was installed on the egress side of the Business Office door. Observation, on 02/19/14 at 11:57 AM, with the Maintenance Director revealed a heavy buildup of lint in the top of the dryers located in the Laundry Room. Interview, on 02/19/14 at 11:57 AM, with the Maintenance Director revealed it was the Maintenance Director's job to ensure the lint was cleaned from the top of the dryers; however, the Maintenance Director for this facility had been on Medical Leave. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for door wedges, slide-bolt locks, or lint removal from the dryers. He stated he was aware door wedges and slide-bolt locks were not permitted; however, he was not aware they were in use. Further interview revealed he was not	K 130	Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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K 130	Continued From page 47 aware of the lint build-up in the top of the dryers. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. NFPA 101 (2000 Edition) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 130		
K 147 SS=E	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 three (3) of four (4) smoke compartments, sixty-six (66) residents, staff, and visitors. The	K 147	1. All extension cords will be removed from room # 3 by 3/28/14. The power strip in room #17 will be taken off the wall by 2/20/14. The attic extension cord will be removed by 2/20/14. The tables in the kitchen will be removed from near the electrical panel by 3/28/14. The electrical panel on B-Hall will be locked by 2/19/14. 2. Weekly audits will be conducted on all electrical panels to ensure they are locked and there are no power cords on wall, by the Maintenance	3/31/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 147	Continued From page 48 facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The findings include: Observations, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed: 1) An oxygen concentrator was plugged into a power strip located in room #13. 2) A power strip was mounted to the wall located in room #17. 3) An extension cord to a television located in room #3. 4) An extension cord running up the wall through the attic access plugged into attic lights located in room #2. 5) An electrical panel was blocked by a table with a microwave located in the Kitchen. 6) An electrical panel located in the B-Hall was not locked. Interview, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director revealed he was not aware the power strips and extension cords were being misused. Further interview revealed he was not aware the electrical panel in the Kitchen was blocked or the electrical panel in the B-Hall had been left unlocked. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for the proper use of power strips and extension cords and for locking or blocking electrical panels. Further interview revealed the Administrator was aware of the proper uses for power strips, extension cords, and requirements	K 147	Director or Administrator. 3. The Maintenance Director or Administrator will be educated to make rounds on new residents to have no extension cords and will document any deficiencies. This will be reviewed monthly for three months and then quarterly. 4. The Maintenance Director or Administrator will monitor egress for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. 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
K 147	Continued From page 49 for electrical panels. Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 edition)	K 147		

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K 147	Continued From page 50 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception. 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around 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. Reference: NFPA 70 (1999 edition) Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K 147		