

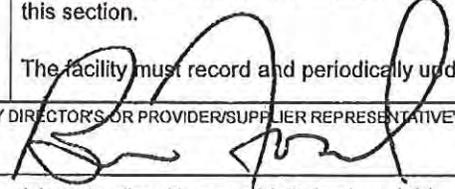
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/14/2013
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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104
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F 000	INITIAL COMMENTS	F 000		
F 157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update</p>	F 157	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: NHA (X6) DATE: 7/8/13

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

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>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 immediately consult with the resident's physician a need to alter treatment for one resident (#1) in the sample of fourteen (14) residents (Resident #1). The facility failed to notify the physician of unrelieved pain during treatments. During a dressing change, on 06/12/13 at 1:15 PM, and on 06/13/13 at 10:00 AM, Resident #1 exhibited verbal/non-verbal signs of pain; however, the nurse continued the treatment without further intervention. On 06/12/13 at 1:15 PM, Resident #1 winced with pain while tears rolled down his/her face as the nurse attempted to remove an old dressing to the right leg.</p> <p>Additionally, on 06/13/13 at 10:15 AM, Resident #1 began complaining of left heel pain. The nurse assessed the resident as having a "red, mushy" area to the left heel with a darkened scabbed area to the left second toe; however, the nurse failed to notify the physician of the pain to the left heel, or the new areas identified.</p> <p>The findings include:</p>	F 157	<p>F157 – Notify of Changes</p> <ol style="list-style-type: none"> 1. The physician was notified of the unrelieved pain for resident #1 by the Director of Nursing on 7/5/13 with new orders noted. The physician was notified of the identified wound to resident #1's left heel on 6/13/13 by the Assistant Director of Nursing with treatment orders noted. 2. A complete skin assessment will be completed on all current residents by 7/28/13 by the Director of Nursing, Assistant Director of Nursing or Unit Manager. Any identified skin impairments will be reviewed to assure that the MD has been notified and an appropriate treatment, if needed, is in place. Any identified skin impairments that have not had MD notification or that does not have an appropriate treatment in place, the facility will contact the physician for notification and/or treatment. A comprehensive pain assessment will be completed on all current residents by 7/28/13 by the Director of Nursing, Assistant Director of Nursing or Unit Manager. Results of the comprehensive pain assessment will be reviewed by the Director of Nursing, Assistant Director of Nursing or Unit Manager to determine if the resident's level of pain exceeds the resident's goals for pain. Any identified as not meeting the resident's goal for level of pain will be reviewed with the physician for further intervention and a follow up pain assessment completed. 	7/28/13	
	<p>Review of the Notification of Resident Change in Condition policy/procedure, undated, revealed clinicians would immediately consult with the resident's physician when there was a significant</p>				

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F 157	<p>Continued From page 2</p> <p>change in the resident's physical, mental, or psychosocial status.</p> <p>Review of the Pain Management Process, dated 03/11, revealed the physician and family would be notified when pain levels were outside normal levels for each individual resident and could not be relieved or interfered with the resident's goal or functional ability.</p> <p>Review of the Skin System policy/procedure, revised 08/08, revealed the physician and family would be notified of any changes of skin condition.</p> <p>Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Anxiety Disorder, Peripheral Vascular Disease, Chronic Ulcer of the Leg, Rheumatoid Arthritis, Pain in Joint, and Muscle Weakness. Review of the significant change Minimum Data Set, dated 05/20/13, revealed the facility identified the resident as moderately cognitively impaired. Review of the Pressure Ulcer Risk Assessment, dated 03/20/13, revealed the facility identified the resident at high risk for pressure ulcers. Review of the Comprehensive Pain Assessment Form, dated 05/20/13, revealed the resident indicated having frequent pain, making it hard to sleep at night and limiting day-to-day activities. The pain assessment indicated the resident's medication/treatments moderately relieved his/her pain. The resident's pain intensity goal was a "4" (four) on the pain scale of 0-10.</p> <p>Review of the Risk for Alteration in Comfort Care Plan, dated 05/20/13, revealed to report unrelieved or unacceptable levels of pain to the</p>	F 157	<p>3. All Licensed staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultant on completion of comprehensive pain assessment, physician notification of unrelieved pain outside the resident's goal for pain levels or pain at unacceptable levels. All Licensed staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultant on identification of skin impairments, notification of the physician and appropriate treatment. Both of these re-education will be completed by 7/28/13 with no Licensed Staff working after 7/28/13 without having received these trainings.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review five (5) resident records per week for twelve (12) weeks to identify any unacceptable levels of pain to assure that the physician has been notified. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe five (5) wound dressings per week for twelve (12) weeks to assure that the resident does not experience pain levels during treatment at unacceptable levels and if the resident does, the nurse will notify the physician of unacceptable pain levels.</p> <p>The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete a look behind skin assessment five (5) times per week for</p>	

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F 157	<p>Continued From page 3 physician as needed.</p> <p>Observation of a dressing change, on 06/12/13 at 1:15 PM, with Registered Nurse #1 (RN) revealed a moderate amount of yellow/bloody drainage to the right leg wound dressing. During the removal of the dressing, the resident was observed wincing in pain with facial grimacing. The dressing appeared to be stuck to the resident's leg and difficult to remove. The resident began to cry, with visible tears rolling down the resident's face, as RN #1 continued to remove the dressing. RN #1 indicated the resident had been "pre-medicated" and continued the dressing removal without any other intervention.</p> <p>Observation of a dressing change, on 06/13/13 at 10:00 AM, revealed old dressings were removed from four (4) wounds on the resident's right side. Resident #1 continuously stated "Oh" during the treatment, dressing change of the wounds. Further observation revealed the resident with facial grimacing and complaints of pain during the treatment. The resident was rolled to the other side while continuously stating "Oh God, please." Observation revealed dressings were removed from three (3) wounds on the resident's left side. During treatment of these wounds, facial grimacing was observed with the resident stating "Oh, please." Throughout the treatment of the wounds, RN #1 stated "Is the pain pill not helping?" and "We are almost done. It's hard on you, isn't it?"</p> <p>Observation, on 06/13/13 at 10:15 AM, revealed Resident #1 continuously complained of pain to the left heel. RN #1 observed the heel to be red and "mushy." She stated "We need to prop that</p>	F 157	<p>twelve (12) weeks. A look behind skin assessment is a skin assessment completed after the direct care nurse has completed a skin assessment to assure that the nurse has identified any new skin impairments and notified the physician of any new skin impairments. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>		

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F 157	<p>Continued From page 4</p> <p>heel up." RN #1 additionally observed a darkened scabbed area to the left second toe.</p> <p>Interview with Resident #1, on 06/13/13 at 5:30 PM, revealed the pain medications were not effective during treatments. He/she revealed the rate of pain during the treatment on 06/13/13 was an "8" eight out of "10" (ten). The resident indicated that was "pretty bad" pain.</p> <p>Observation of Resident #1, on 06/14/13 at 10:45 AM, revealed a red, non-blanchable area to the left heel per assessment of the Assistant Director of Nursing (ADON). She indicated the area was "boggy" underneath. At approximately 10:55 AM, a blister had ruptured on the left heel with serous drainage noted. Additionally, an unstageable area to the left second toe measured 1 x 1.4 centimeters (cm).</p> <p>Record review, on 06/14/13, revealed no documentation related to the left heel/left second toe. Further review revealed no documented evidence new orders were initiated.</p> <p>Interview with RN #1, on 06/14/13 at 10:10 AM, revealed she had not notified the resident's physician of unrelieved pain. She indicated Resident #1 always had pain during treatments. She stated the resident feared the treatment before it even started. RN #1 stated the resident had anxiety disorder, which was "a lot of the problem." When a resident complained of pain before touching them, it had to be determined anxiety. She revealed the resident's pain management was effective for him/her as the resident's behavior during treatments on 06/12/13 and 06/13/13 was "typical."</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>Continued interview with RN #1, on 06/14/13 at 10:10 AM, revealed she had not noticed the red, "mushy" area to the resident's left heel prior to the assessment, on 06/13/13. She did not report the resident's pain to the left heel as she did not feel it was significant. She revealed the ADON was notified of the area; however, interview with the ADON, on 06/14/13 at 3:50 PM, revealed she had no knowledge of the area prior to observation with the state surveyor. Further interview with RN #1 revealed she did not report the area to the left second toe; however, she should have made the ADON aware. She stated it was "up in the air" whose responsibility it was to notify the physician of the new areas. She revealed it was "probably" her responsibility since she found the new areas.</p> <p>Interview with the Director of Nursing (DON), on 06/14/13 at 4:45 PM, revealed she expected staff to try other measures for relief during treatments and call the physician if pain continued.</p> <p>An attempted interview with Resident #1's primary physician, on 06/14/13 at 10:35 AM, revealed he was not available for interview.</p> <p>Interview with the ADON, on 06/14/13 at 10:45 AM, revealed if a new wound was discovered, it would be the nurse's responsibility to notify the physician.</p> <p>Interview with the DON, on 06/14/13 at 4:45 PM, revealed she expected the nurse to assess, document, and notify the physician of any new areas identified.</p> <p>Interview with the Medical Director, on 06/14/13</p>	F 157			

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F 157	Continued From page 8 at 2:00 PM, revealed he would expect staff to notify the physician of any new areas identified on a resident. Continued interview with the Medical Director, revealed he would expect staff to notify the physician if pain medication was not effective during a treatment.	F 157			
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on Interview, observation and record review and facility policy; it was determined the facility failed to ensure the residents' environment was comfortable and homelike related to the absence of window coverings in five (5) of thirty-four (34) residents' rooms. The findings include: Observations on 06/12/13 at 6:30 AM and on 06/14/13 at 3:45 PM, revealed five residents' rooms (rooms 1, 2, 11 and 34) revealed the windows had no window coverings such as blinds, shades, and/or curtains. Interview with Assistant Director of Nursing (ADON), on 06/14/13 at 3:45 PM, revealed the window coverings were a housekeeping and/or maintenance issue. The ADON stated she was not aware there were resident rooms without window coverings for the outside wall windows.	F 252	F252 – Safe/Clean/Comfortable/ Homelike Environment 1. The identified resident rooms # 1,2,11 and 34 will have window blinds installed by the Maintenance director by 7/12/13. 2. The Administrator and Housekeeping supervisor will complete an audit of all resident rooms to assure that they have window coverings and present a comfortable home like environment by 7/28/13. Any identified as not being homelike and comfortable or without window coverings will be made comfortable and homelike or have window coverings installed by 7/28/13. 3. The Administrator will re-educate the Housekeeping Supervisor by 7/28/13 on the requirement of a comfortable home like environment and window coverings. 4. The Administrator and Housekeeping Supervisor will complete weekly audits of all resident rooms for twelve (12) weeks to assure that all rooms have window coverings and present as comfortable and homelike. The results of these audits will be	7/28/13	

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F 252	Continued From page 7 The ADON revealed the absence of window coverings put resident's privacy at risk. Interview with Director of Nursing (DON), on 06/14/13 at 4:15 PM, revealed she did not know who was responsible for ensuring the residents' rooms had window coverings, but each window should have something. Interview with the Housekeeping Supervisor in the presence of the Environmental Services District Manager, on 06/14/13 at 4:50 PM; revealed he/she was not aware there were resident rooms without blinds, curtains, or shades. The Housekeeping Supervisor stated the resident rooms should be homelike and have curtains or blinds covering an outside window to ensure privacy for the resident.	F 252	reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of fourteen (14) sampled residents (Resident #1). The facility failed to follow physician's orders related to a daily dressing change to the resident's right leg. The findings include: The facility had no specific policy related to	F 281	F281 – Services Provided Meet Professional Standards 1. The dressings for resident # 1 were noted to be changed per physician order by the Director of Nursing on 7/8/13. 2. A review of all current residents' physician orders for the past 30 days will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure all physician orders have been followed or the physician has been notified if unable to follow the order. Any identified as not being followed without physician notification will have physician notification for further direction. An observation of all wound dressings will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure treatment were completed per physician orders. Any identified as not	7/28/13

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F 281	<p>Continued From page 8 following physician's orders.</p> <p>Observation, on 06/13/13 at 5:30 PM, revealed a dressing intact to the resident's right leg, dated 06/12/13. There was a large amount of brownish/pink tinged drainage observed on the outside of the dressing, as well as a towel laying under the resident's leg.</p> <p>Interview with the Resident #1's husband, on 06/13/13 at 5:30 PM, revealed the nurse said she was going to change the dressing; however she did not.</p> <p>Observation, on 06/14/13 at 8:10 AM, revealed a dressing intact to the resident's right leg, dated 06/14/13.</p> <p>Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Peripheral Vascular Disease and Chronic Ulcer of the Leg. Review of the Significant Change Minimum Data Set (MDS), dated 05/20/13, revealed the facility identified the resident as moderately cognitively impaired and required extensive assistance with bed mobility and transfer.</p> <p>Review of the Physician's Orders, dated 05/30/13, and the Treatment Administration Record (TAR), dated June 2013, revealed an order for Solosite Hydrogel Wound (wet-to-dry) dressing topically, daily to the right calf. A copy of the TAR was received by the surveyor, on 06/13/13 at 5:45 PM. The TAR revealed an order to complete the treatment on dayshift (6:00 AM-2:00 PM); however, it was not initiated as being completed on 06/13/13.</p>	F 281	<p>will have MD notification for further direction.</p> <p>3. All Licensed Nurses will be re-educated on following physician orders and notification of the physician if unable to follow the physician orders. This re-education will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager and will be completed by 7/28/13 with no licensed nurse working past 7/28/13 without having received this re-education.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit five (5) resident's medical records weekly for twelve (12) weeks to assure physician orders have been followed or the physician was notified if unable to follow. In addition, the Director of Nursing, Assistant Director of Nursing or Unit Manager will audit five (5) wound treatments per week for twelve (12) weeks to assure the treatment was completed per physician order. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>	

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F 281	Continued From page 9 Interview with Resident #1, on 06/14/13 at 9:25 AM, revealed staff did not change the dressing on 06/13/13. It was changed after his/her bath, on 06/14/13. Interview with the Assistant Director of Nursing (ADON), on 06/14/13 at 3:50 PM, revealed the treatment to the resident's right leg was completed by her, on 06/14/13 at approximately 6:45 AM. She indicated the dressing had been removed prior to the treatment; therefore, she was unsure of the date on the old dressing. Interview with Registered Nurse (RN) #1, on 06/14/13 at 10:10 AM, verified she did not complete the treatment for Resident #1, on 06/13/13. RN #1 revealed it was reported to the Dayshift Charge Nurse, Licensed Practical Nurse (LPN) #1, who indicated she would change the dressing. Interview with LPN #1, on 06/14/13 at 2:40 PM, revealed she was the Dayshift Charge Nurse on 06/13/13. She further stated the Charge Nurse typically completed treatments; however, she thought RN #1 completed the dressing change for Resident #1. Interview with LPN #2, on 06/14/13 at 9:45 AM, revealed she was the nurse on evening shift for Resident #1, on 06/13/13. She stated she did not complete the treatment to the resident's right leg on 06/13/13. Interview with the Director of Nursing (DON), on 06/14/13 at 4:45 PM, revealed she expected staff to complete treatments, per the physician's	F 281			

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F 281	Continued From page 10 orders.	F 281		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>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 ensure services were provided by qualified persons in accordance with each resident's written plan of care for one (1) of fourteen (14) sampled residents (Resident #1).</p> <p>The findings include: Review of the guidelines for the Resident Comprehensive Care Plan, dated 09/08, revealed the resident's Comprehensive Care Plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility.</p> <p>Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Anxiety Disorder, Peripheral Vascular Disease, Chronic Ulcer of the Leg, Rheumatoid Arthritis, Pain in Joint, and Muscle Weakness. Review of the Significant Change Minimum Data Set (MDS), dated 05/20/13, revealed the facility</p>	F 282	<p>F282 – Services by Qualified Persons/Per Care Plan</p> <ol style="list-style-type: none"> 1. The Assistant Director of Nursing observed on 7/5/13 that resident # 1's care plan interventions were being followed; that staff had documented pain location; rate of pain prior to and after intervention and the dressing change was completed without exceeding the resident's stated pain goal. 2. A complete audit of all resident's records will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure all care plan interventions are in place. Any intervention not in place will be implemented. 3. All Licensed Nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Manager on the requirement to follow the resident's plan of care to include rating pain before and after treatment including location of pain, report unrelieved pain or unacceptable pain levels to the physician and stop treatment if unacceptable pain implement further intervention before resuming treatment. This re-education will be completed by 7/28/13. 4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit five (5) resident's pain flow 	7/28/13

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F 282	<p>Continued From page 11</p> <p>Identified the resident as moderately cognitively impaired. Review of the Comprehensive Pain Assessment Form, dated 05/20/13, revealed the resident indicated having frequent pain, making it hard to sleep at night and limiting day-to-day activities. The pain assessment indicated the resident's medication/treatments moderately relieved his/her pain. The resident's pain intensity goal was a "4" (four) on the pain scale of 0-10 (zero to ten).</p> <p>Review of the Risk for Alteration in Comfort Care Plan, dated 05/20/13, revealed to identify the location and rate of pain prior to and after any interventions. Report unrelieved or unacceptable levels of pain to the physician as needed.</p> <p>Review of the Controlled Substance Proof of Use sheet, dated 06/12/13, revealed Registered Nurse (RN) #1 administered Dilaudid (pain medication) 4 milligram (mg) to Resident #1 at 7:05 AM. Review of the Medication Administration Record (MAR), dated 06/12/13 at 7:05 AM, revealed the Dilaudid was administered for generalized pain; however, there was no rate of pain documented. Further review of the MAR revealed the resident's pain had decreased at 8:00 AM, but no rate of pain was noted.</p> <p>Observation, on 06/12/13 at 10:00 AM, revealed Resident #1 was sitting up in his/her room, after completing physical therapy. The resident complained of his/her "bottom" hurting and appeared uncomfortable.</p> <p>Observation, on 06/12/13 at 10:15 AM, revealed a staff member reported the resident's pain to Registered Nurse (RN) #1 with the state surveyor</p>	F 282	<p>sheets per week for twelve (12) weeks to assure pain rate before and after intervention and location of pain are documented, that the physician was notified of any unrelieved or unacceptable levels of pain to the physician. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe five (5) wound dressing changes per week to assure that the pain is relieved or at acceptable levels or the nurse stops treatment for further intervention. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>	

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F 282	<p>Continued From page 12 present. At 10:30 AM, the resident remained in the wheelchair with facial grimacing.</p> <p>Further observation, on 06/12/13 at 11:50 AM, revealed Resident #1 remained up in his/her room. The resident revealed his/her "bottom" was still hurting "pretty bad."</p> <p>Review of the Controlled Substance Proof of Use sheet, dated 06/12/13, revealed RN #1 administered Dilaudid 4 mg at 12:40 PM. Review of the MAR, dated June 2013, revealed no documentation of the location, rate of pain, or effectiveness of the medication given at 12:40 PM.</p> <p>Interview with RN #1, on 06/14/13 at 10:10 PM and 3:00 PM, revealed she "tried" to look at the care plans as she charted on residents. She was aware documentation of pain medication included the location, rate of pain, and a re-evaluation; however, she was unsure of the reason it was not documented on 06/12/13. She did not give the resident pain medication when asked, on 06/12/13 at 10:15 AM, as it was not time for a dose. She revealed the physician was not notified of unrelieved pain, per the care plan.</p> <p>Review of the Impaired Skin Integrity Care Plan, dated 05/20/13, revealed if there was complaints of pain during a treatment, stop the treatment, leave the resident safe, and seek pain relief. Return to complete the treatment when the pain was reported as acceptable.</p> <p>Observation of a dressing change, on 06/12/13 at 1:15 PM, revealed a moderate amount of yellow/bloody drainage to the right leg wound</p>	F 282		

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F 282	<p>Continued From page 13</p> <p>dressing. During the removal of the dressing, the resident was wincing in pain with facial grimacing. Further observation revealed the dressing appeared to be stuck to the resident's leg and was difficult to remove. The resident began to cry, with visible tears rolling down the resident's face, as RN #1 continued to remove the dressing. RN #1 indicated the resident had been "pre-medicated" and continued removing the dressing without implementing any other intervention.</p> <p>Observation of a dressing change, on 06/13/13 at 10:00 AM, revealed old dressings were removed from four (4) wounds on the resident's right side. Further observation revealed Resident #1 continuously stated "Oh" during the treatment/dressing of the wounds. Observation revealed facial grimacing and complaints of pain during the treatment. The resident was rolled to the other side while continuously stating "Oh God, please." Dressings were removed from three (3) wounds on the resident's left side. During treatment of these wounds, facial grimacing was observed with the resident stating "Oh, please." Throughout the treatment of the wounds, RN #1 stated "Is the pain pill not helping?" and "We are almost done. It's hard on you, isn't it?"</p> <p>Interview with RN #1, on 06/14/13 at 10:00 AM and 3:00 PM, revealed Resident #1 always had pain during treatments. She revealed the resident's pain management was effective for him/her as the resident's behavior during treatments on 06/12/13 and 06/13/13 was "typical."</p> <p>Interview with the Director of Nursing (DON), on</p>	F 282		

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F 282	Continued From page 14 06/14/13 at 4:45 PM, revealed she felt the interventions on Resident #1's care plan were generic and should have been more individualized; however, she still expected staff to follow the interventions.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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 ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the plan of care for one (1) of fourteen (14) sampled residents (Resident #1). On 06/12/13, Resident #1 complained of unrelieved pain three (3) hours after pain medication was given; however, he/she did not receive any further intervention until the next "as needed" dose of medication could be given. During a wound treatment, on 06/12/13 at 1:15 PM, Resident #1 was observed wincing in pain with tears rolling down his/her face; however,	F 309	F309 – Provide Care/Services for Highest Well Being 1. A comprehensive pain assessment was completed on Resident # 1 on 7/5/13 by the Director of Nursing that indicated her new pain regimen was effective. The Assistant Director of Nursing noted on 7/5/13 during a wound treatment that the resident did not exhibit any signs or symptoms of pain greater than the stated pain goal. The Director of Nursing noted on 7/8/13 that staff documented pain before and after as needed pain medication was given on 7/8/13. 2. A comprehensive pain assessment will be completed on all current residents by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure that all residents pain interventions are effective for their goals. Any identified as not being effective will have physician notification with further interventions and reassessment. An observation of all current residents with wound treatment dressing orders will be completed by 7/28/13 by the Director of Nursing, Assistant Director of Nursing	7/28/13

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F 309	<p>Continued From page 15</p> <p>the nurse continued the treatment with no further intervention. Resident #1 exhibited non-verbal and verbal signs of pain during a wound treatment, on 06/13/13 at 10:00 AM; however, the nurse continued the treatment without further intervention. Additionally, the facility failed to assess and document the resident's pain before and after pain medication was administered.</p> <p>The findings include:</p> <p>Review of the Pain Management Process policy/procedure, dated 03/11, revealed the facility would react to the resident's pain control needs based on the resident's goals for pain relief and the resident's goals for functional ability. The facility's goal was to ensure all residents received appropriate pain relief measures to assure that the residents' pain did not affect their ability to function within their designated goals for functional ability. Documentation of pain intensity would be recorded along with the intervention for pain reduction using appropriate facility forms. A post intensity evaluation would be assessed and documented in a timely manner. Upon follow-up, if the intervention was ineffective, the process should be repeated until the resident indicated adequate relieve and/or functional goals were met.</p> <p>Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Anxiety Disorder, Peripheral Vascular Disease; Chronic Ulcer of the Leg; Rheumatoid Arthritis, Pain in Joint, and Muscle Weakness. Review of the Significant Change Minimum Data Set, dated 05/20/13, revealed the facility identified the resident as moderately cognitively impaired</p>	F 309	<p>or Unit Manager to ensure that all residents with wound treatment interventions are effective. Any noted to have pain during treatment not relieved by interventions will have physician notification with further interventions and follow up assessment completed. An audit of all current residents who receive as needed pain medications will be reviewed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure that pain is assessed before and after as needed pain medications are administered. Any identified as not having pain rated before and after pain medication administrated will have a pain assessment completed with follow up with the physician for pain levels unrelieved or unacceptable for further intervention and follow up assessment completed. These audits will be completed by 7/28/13.</p> <p>3. All Licensed Nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultant related to pain assessments, pain goals and physician notification related to unacceptable pain levels: stopping treatment with unacceptable levels of pain with further intervention before resuming treatment as well as documentation of pain levels before and after administration of as needed pain medication. This re-education will be completed by 7/28/13.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager</p>	

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F 309	<p>Continued From page 16</p> <p>and required extensive assistance with bed mobility and transfer. Review of the Comprehensive Pain Assessment Form, dated 05/20/13, revealed the resident indicated having frequent pain, making it hard to sleep at night and limiting day-to-day activities. The pain assessment indicated the resident's medication/treatments moderately relieved his/her pain. The resident's pain intensity goal was a "4" on the pain scale of 0-10.</p> <p>Review of the Physician's Orders, dated 06/01/13 through 06/30/13, revealed an order for the following pain medications:</p> <ol style="list-style-type: none"> 1. Fentanyl (controlled pain medication) 100 microgram (mcg)/hour patch, one patch topically every seventy-two (72) hours 2. Hydromorphone (Dilaudid, controlled pain medication) 4 milligram (mg) tablet every six (6) hours, as needed, and 3. Acetaminophen (pain medication) 325 mg tablet every four (4) hours, as needed <p>Review of the Risk for Alteration in Comfort Care Plan, dated 05/20/13, revealed to identify the location and rate of pain prior to and after any interventions. Report unrelieved or unacceptable levels of pain to the physician as needed.</p> <p>Review of the Controlled Substance Proof of Use sheet, dated 06/12/13, revealed Registered Nurse (RN) #1 administered Dilaudid 4 mg to Resident #1 at 7:05 AM. Review of the Medication Administration Record (MAR), dated 06/12/13 at 7:05 AM, revealed the Dilaudid was administered for generalized pain; however, there was no rate of pain documented. Further review of the MAR revealed the resident's pain had</p>	F 309	<p>will audit five (5) resident's pain flow sheets per week for twelve (12) weeks to assure pain rate before and after intervention and location of pain are documented, that the physician was notified of any unrelieved or unacceptable levels of pain to the physician. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe five (5) wound dressing changes per week to assure that the pain is relieved or at acceptable levels or the nurse stops treatment for further intervention. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>	

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F 309	<p>Continued From page 17</p> <p>decreased at 8:00 AM, but no rate of pain was noted.</p> <p>Observation, on 06/12/13 at 10:00 AM, revealed Resident #1 was sitting up in his/her room, after completing physical therapy. The resident complained of his/her "bottom" hurting and appeared uncomfortable.</p> <p>Observation, on 06/12/13 at 10:15 AM, revealed a staff member reported the resident's pain to Registered Nurse (RN) #1 with the state surveyor present. At 10:30 AM, the resident remained in the wheelchair with facial grimacing.</p> <p>Further observation, on 06/12/13 at 11:50 AM, revealed Resident #1 remained up in his/her room. The resident revealed his/her "bottom" was still hurting "pretty bad."</p> <p>Review of the Controlled Substance Proof of Use sheet, dated 06/12/13, revealed RN #1 administered Dilaudid 4 mg at 12:40 PM. Review of the MAR, dated June 2013, revealed no documentation of the location, rate of pain, or effectiveness of the medication given at 12:40 PM.</p> <p>Review of the Impaired Skin Integrity Care Plan, dated 05/20/13, revealed if there was complaints of pain during a treatment, stop the treatment, leave the resident safe, and seek pain relief. Return to complete the treatment when the pain was reported as acceptable.</p> <p>Observation of a dressing change, on 06/12/13 at 1:15 PM, revealed a moderate amount of yellow/bloody drainage to the right leg wound</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>dressing. During the removal of the dressing, the resident was wincing in pain with facial grimacing. Further observation revealed the dressing appeared to be stuck to the resident's leg and was difficult to remove. The resident began to cry, with visible tears rolling down the resident's face, as RN #1 continued to remove the dressing. RN #1 indicated the resident had been "pre-medicated" and continued removing the dressing without implementing any other intervention.</p> <p>Review of the Controlled Substance Proof of Use sheet, dated 06/13/13, revealed RN #1 administered Dilaudid 4 mg at 8:00 AM. Review of the MAR, dated June 2013, revealed no documentation of the location, rate of pain, or effectiveness of the medication given at 8:00 AM.</p> <p>Observation of a dressing change, on 06/13/13 at 10:00 AM, revealed old dressings were removed from four (4) wounds on the resident's right side. Further observation revealed Resident #1 continuously stated "Oh" during the treatment/dressing of the wounds. Observation revealed facial grimacing and complaints of pain during the treatment. The resident was rolled to the other side while continuously stating "Oh God, please." Dressings were removed from three (3) wounds on the resident's left side. During treatment of these wounds, facial grimacing was observed with the resident stating "Oh, please." Throughout the treatment of the wounds, RN #1 stated "Is the pain pill not helping?" and "We are almost done. It's hard on you, isn't it?"</p> <p>Interview with Resident #1, on 06/13/13 at 5:30 PM, revealed pain medications were not effective</p>	F 309			

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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. 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
F 309	<p>Continued From page 19</p> <p>during treatments. The resident stated it may be better if staff give him/her pain medications before the pain was so bad. He/she revealed the rate of pain during the treatment on 06/13/13 was an "8" out of "10." The resident indicated that was "pretty bad" pain.</p> <p>Interview with Resident #1's husband, on 06/13/13 at 5:30 PM, revealed the pain had actually improved as the resident used to "squawl out" during treatments. He indicated the resident sometimes had to ask three (3) times before getting pain medications.</p> <p>Interview with RN #1, on 06/14/13 at 10:00 AM and 3:00 PM, revealed pain medication was not given when asked on 06/12/13 as it was not time for the medication. She revealed the resident was assessed and informed that it was not time for pain medication. Further interview with RN#1 revealed she had not notified the resident's physician of the resident's unrelieved pain. She indicated Resident #1 always had pain during treatments. She stated the resident feared the treatment before it even starts. She stated the resident had anxiety disorder, which was "a lot of the problem." She stated when a resident complained of pain before touching them, then it had to be due to the resident's anxiety. She revealed documentation of pain medications included the location of the pain pain, rate of pain, and effectiveness; however, she was unsure of the reason it was not documented on 06/12/13 or 06/13/13. She revealed the resident's pain management was effective for him/her as the resident's behavior during treatments on 06/12/13 and 06/13/13 was "typical."</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 309	Continued From page 20 Interview with the Director of Nursing (DON), on 06/14/13 at 4:45 PM, revealed documentation of pain included the rate of pain. The DON stated she expected staff to reassess and document within the hour after a pain medication was given. She felt the interventions on Resident #1's care plan were generic and should have been more individualized; however, she still expected staff to follow the interventions. She stated staff should try non-pharmalogical interventions if it was not time for pain medication but if a resident continued to complain of pain, the physician should be notified. She expected staff to try other measures for relief during treatments and call the physician if pain continued. An attempt to interview Resident #1's primary physician, on 06/14/13 at 10:35 AM, revealed he was not available for interview. Interview with the Medical Director, on 06/14/13 at 2:00 PM, revealed he would expect staff to notify the physician if the pain medication was not effective during a treatment.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314 – Treatment/Svcs to Prevent/Heal Pressure Sores 1. The physician was notified of resident # 1's pressure ulcer on 6/13/13 by the Assistant Director of Nursing with an appropriate treatment put in place. 2. A complete skin assessment will be completed on all current residents by 7/28/13 by the Director of Nursing, Assistant Director of Nursing or Unit Manager. Any identified skin impairments will be reviewed to assure that the MD has been notified, documentation complete and an appropriate treatment if needed are in place. Any identified skin impairments that have not had MD notification or	7/28/13	

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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104
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F 314	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure a resident having pressure sores received necessary treatment and services to promote healing for one (1) of fourteen (14) sampled residents (Resident #1). A skin assessment for Resident #1 revealed the nurse identified a "red, mushy" area on the resident's left heel, and a darkened scabbed area to the left second toe; however, the nurse did not assess, document, or notify the physician of the new areas to ensure an appropriate treatment was in place to promote healing.</p> <p>The findings include:</p> <p>Review of the Skin System policy/procedure, revised 08/08, revealed on admission and when observed skin was compromised, the nurse finding the problem would initiate a treatment using a formulary product, if possible and physician approval. Physician and family would be notified at the time of discovery and notification would be documented in the medical record.</p> <p>Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Peripheral Vascular Disease, Chronic Ulcer of the Leg, Rheumatoid Arthritis, Pain in Joint, and Muscle Weakness. Review of the significant change Minimum Data Set (MDS), dated 05/20/13, revealed the facility identified the resident as moderately cognitively impaired. Review of the Pressure Ulcer Risk Assessment,</p>	F 314	<p>that does not have an appropriate treatment in place, the facility will contact the physician for notification and or treatment.</p> <p>3. All Licensed Nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultant on assessing, documentation, physician notification and appropriate treatment for pressure ulcers. This re-education will be completed by 7/28/13 with no Licensed Nurse working after 7/28/13 without having receiving this training.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete a look behind skin assessment five (5) times per week for twelve (12) weeks. A look behind skin assessment is a skin assessment completed after the direct care nurse has completed a skin assessment to assure that the nurse has identified any new skin impairments documented the skin impairment and notified the physician of any new skin impairments for appropriate treatment if needed. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social</p>	
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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1661 NEWTON AVE. BOWLING GREEN, KY 42104		
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F 314	<p>Continued From page 22</p> <p>dated 03/20/13, revealed the facility identified the resident at high risk for pressure ulcers.</p> <p>Observation, on 06/13/13 at 10:15 AM, revealed Resident #1 complained of pain to the left heel. Upon observation by Registered Nurse (RN) #1, the left heel was described as "red, mushy." RN #1 made the statement the heel needed to be "propped up." Additionally, RN #1 identified a darkened scabbed area on the resident's left second toe.</p> <p>Record review, on 06/14/13 at 9:00 AM, revealed no documentation of the area identified to the resident's left heel or left second toe. There were no new treatments initiated.</p> <p>Observation with the Assistant Director of Nursing (ADON), on 06/14/13 at 10:45 AM, revealed the resident's left heel was red and non-blanchable. The ADON revealed it was "boggy" underneath. The ADON left the room to obtain supplies to assess the wound. Approximately ten (10) minutes later, yellow drainage was noted to the bed as the "blister" had ruptured. The ADON assessed the area as a "Stage 2" measuring 1.2 centimeters (cm) in length by 1.1 cm width. She assessed the darkened scabbed area to the left second toe as "unstageable" measuring 1.0 cm in length by 1.4 cm width (possibly an arterial or venous ulcer).</p> <p>Interview with RN #1, on 06/14/13 at 10:10 AM, revealed she identified the area to the resident's left heel, on 06/13/13. She revealed the ADON was made aware and would be responsible to notify the physician for a treatment plan. She revealed the increased pain to the left heel was</p>	F 314	Services Director with the Medical Director attending at least quarterly.		

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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1551 NEWTON AVE. BOWLING GREEN, KY 42104	
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F 314	Continued From page 23 not addressed as she did not feel it was significant. RN #1 revealed the darkened scabbed area to the left second toe was identified on 06/13/13; however, she did not address the findings. She revealed the ADON should have been made aware. She indicated it was "probably" her responsibility to notify the physician of both areas, since she was the identifying nurse. Interview with the ADON, on 06/14/13 at 10:45 AM, revealed she was not aware of the newly identified areas on 06/13/13. She revealed RN #1 should have assessed, measured, and documented the wounds, as well as notified the physician for a treatment plan. Interview with the Director of Nursing (DON), on 06/14/13 at 4:45 PM, revealed the ADON assessed and measured wounds weekly; however, if new areas were identified, it would be that nurse's responsibility to assess, document, and notify the physician for treatment.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 – Free of Accident Hazards/ Supervision/Devices 1. The knife for resident # 12 was removed by a CNA on 6/12/13. 2. A facility wide audit was completed by the Administrator and Maintenance Director on 7/17/13 to identify any environmental hazards including knives. No other identified environmental hazards were identified. 3. All facility staff will be re-educated by the Administrator, Director of Nursing, Assistant Director of Nursing of Unit Manager related to promoting a safe environment including residents using sharp objects to include knives and scissors. This education will be completed by 7/28/13 with no staff	7/28/13
	This REQUIREMENT is not met as evidenced			

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F 323	Continued From page 24 by: Based on observation and interview it was determined the facility failed to ensure the resident environment remained as free of accident hazards as is possible related to sharp knives observed being kept unsecured in a resident's room. The findings include: Review of the facility's Admission Agreement, dated 07/01/12, revealed under the responsibilities Section #9: "The resident agrees that if the presence of any of his or her personal possessions violates local, State, Federal laws, rules, or regulations, or policies of the Center, the Center has the right to require the resident to remove them or to seek assistance from appropriate authorities to assist in the removal of such possessions". A record review revealed Resident #12 was admitted to the facility on 03/11/13 with diagnoses to include Diabetes Mellitus and Congestive Heart Failure. A review of the admission Minimum Data Set assessment, dated 03/18/13 revealed the facility assessed the resident as cognitively intact. There was no evidence an assessment was completed to determine if it was safe for the resident to store knives in his/her room. Observation on 06/12/13 at 6:30 AM, during the initial tour, revealed Resident #12 was in his/her room. Interview with the resident at this time revealed the resident was confused. Observation on 06/12/13 at 12:00 PM, revealed the lunch meal being served to Resident #12 in	F 323	working after 7/28/13 without having received this education. 4. The Administrator, Director of Nursing, Assistant Director of Nursing or Unit Manager will complete weekly audits for twelve (12) weeks of the facility to assure that no unsafe objects are unsecured. The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete a look behind skin assessment five (5) times per week for twelve (12) weeks. A look behind skin assessment is a skin assessment completed after the direct care nurse has completed a skin assessment to assure that the nurse has identified any new skin impairments and notified the physician of any new skin impairments. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.		

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F 323	<p>Continued From page 25</p> <p>his/her room. Resident #12 did not want what was being served and requested the Certified Nurse Aide (CNA) #1 to obtain ring bologna from the resident's personal refrigerator located in the room and a knife to cut the bologna. The CNA obtained the bologna from the refrigerator and then got a sharp knife from the bed side night stand top drawer. Observation, at the time revealed two (2) sharp knives, unsecured, in the top drawer of the Resident #12's bed side night stand.</p> <p>Interview with CNA #1, on 06/12/13 at 12:50 PM, revealed sharp objects were never to be unsecured in residents' rooms and she did not know how long Resident #12 had the sharp knives. The CNA reported the sharp knives she had observed to her supervisor after serving Resident #12's lunch.</p> <p>Interview on 06/12 13 at 3:45 PM, with the Assistant Director of Nursing (ADON), revealed residents were not permitted to keep sharp knives in a drawer unsecured because there was a potential for injury as multiple residents who were confused and wandered.</p> <p>Interview with the Director of Nursing (DON), on 06/12/13 at 3:50 PM, revealed no resident was to have any sharp object in their room that was not secured. It was the responsibility of everyone to observe and ensure sharp objects were not left unsecured.</p>	F 323			

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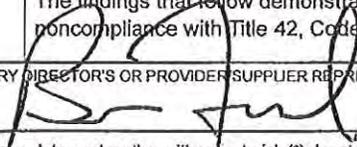
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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1962.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1962, with 21 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1962 and upgraded in 2010.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 06-12-13. Bowling Green Nursing and Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>THE SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION BY THE PROVIDER OF ANY FACT OR CONCLUSION SET FORTH IN THE STATEMENT OF DEFICIENCY. THIS PLAN OF CORRECTION IS BEING SUBMITTED BECAUSE IT IS REQUIRED BY LAW.</p> 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 7/8/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 025 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD 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 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 four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure two (2) smoke barriers were sealed around pipes and wires to resist the passage of smoke and failed to be complete from outside wall to outside wall. The findings include:	K 025	K 025 -- Life Safety Code 1. The wire chase in the smoke partitions extending above the ceiling located at room #11 will be sealed properly by the Maintenance Director by 7/28/13. The concrete firewall located at room #2 will be re-sealed using proper sealant by the Maintenance Director by 7/28/13. The smoke barrier at room #35 will be extended to go around the bathroom located in the room by 7/28/13. 2. An audit of all fire walls and smoke barriers will be completed by the Maintenance Director by 7/28/13 to ensure all penetrations are sealed with the proper sealant and to ensure that the smoke barriers cover all areas appropriately. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on the requirements regarding fire walls and smoke barriers. 4. The Maintenance Director will complete an audit of all fire walls and smoke barriers on a monthly basis for three (3) months to ensure all penetrations are sealed with the proper sealant and to ensure that the smoke barriers cover all areas appropriately. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The	7/29/13

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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1581 NEWTON AVE. BOWLING GREEN, KY 42104	
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K 025	Continued From page 2 Observations, on 06/12/13 between 8:41 AM and 9:30 AM with the Maintenance Director, revealed the smoke partitions, extending above the ceiling located at room #11 had 1 foot by 1 foot wire chase that was not sealed and yellow foam was used as a sealant on the concrete smoke barrier. Further observation revealed drywall mud was used as a sealant on a concrete firewall located at room #2. The smoke barrier at room #35 does not go around the bathroom located in the room. The barrier is therefore compromised due to the opening for the bathroom. Interview, on 06/12/13 between 8:41 AM and 9:30 AM with the Maintenance Director, revealed he was aware of some work completed at the barrier at room #11 and he instructed the contractors to seal the wall once they were finished. The Maintenance Director was unaware drywall mud was not a proper sealant on concrete fire walls. Further interview revealed he was unaware the bathroom door located in a smoke barrier compromised the barrier. Reference: NFPA 101 (2000 Edition). 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: (a) The space between the penetrating item and the smoke barrier shall 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.	K 025	Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	

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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 025	Continued From page 3 (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 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. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 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.	K 025		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive	K 027	K 027 – Life Safety Code 1. The cross-corridor doors located on B Hall and the back of A Hall will be repaired by 7/28/13 to ensure that they close properly. 2. All fire doors will be observed by the Maintenance Director by 7/28/13 to ensure they meet the requirements of closing properly. Identified concerns will be corrected at that time. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on	7/29/13

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PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

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K 027	<p>Continued From page 4 latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure two (2) doors in the smoke barriers had a gap less than 1/8 inch where the doors meet.</p> <p>The findings include:</p> <p>Observation, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed the cross-corridor doors located on the B hall would not close completely when tested, leaving a gap of approximately one inch or greater between the pair of doors and would not resist the passage of smoke. Further observation revealed the doors at the back of A hall also gap a gap larger than 1/4 of an inch.</p> <p>Interview, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position.</p>	K 027	<p>the requirements related to the proper closing of fire doors.</p> <p>4. The fire doors will be audited by testing them monthly for three (3) months to ensure they close properly. This will be completed by the Maintenance Director. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>	

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K 027	Continued From page 5 Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027			
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¼ 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 deficiency had the potential to affect one (1) of	K 029	K 029 – Life Safety Code 1. The three (3) shred bins located in the copy area were relocated to areas with automatic closing doors by the Maintenance Director on 7/1/13. 2. A complete audit of the facility was completed by the Maintenance Director on 7/1/13 to ensure there were no other areas affected by this practice. No other areas were identified. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on the requirements of protection of hazards. 4. The Maintenance Director will audit all areas of the facility monthly for three (3) months to ensure shred bins are located behind automatic closing doors. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further	7/29/13	

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K 029	<p>Continued From page 6</p> <p>four (4) smoke compartments, four (4) residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the shred bins located in the copy area were protected from the corridor.</p> <p>The findings include:</p> <p>Observations, on 06/12/13 at 2:00 PM with the Maintenance Director, revealed the copy area for the facility was located in an area open to the corridor. The area had three (3) shred it bins that were stored in the area with no separation from the corridor.</p> <p>Interview, on 06/12/13 at 2:00 PM with the Maintenance Director, revealed he was unaware the combustibles could not be stored in an area open to the corridor</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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</p>	K 029	<p>recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>	

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PRINTED: 08/28/2013
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OMB NO. 0938-0391

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K 029	Continued From page 7 (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), 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 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke	K 038	K 038 – Life Safety Code 1. The side door exit, back B Hall exit, back A Hall exit will be equipped with delayed egress signage with contrasting background and unobstructed view by the Maintenance Director by 7/28/13. 2. An audit of all exit doors will be completed by the Maintenance Director by 7/28/13 to ensure they are equipped with delayed egress signage with contrasting background and unobstructed view. Any identified concerns will be immediately corrected. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on	7/29/13

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K 038	<p>Continued From page 8</p> <p>compartments, all residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure three (3) egress doors had the proper signage for delayed egress doors.</p> <p>The findings include:</p> <p>Observation, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed the side door exit was equipped with delayed egress signage but did not have a contrasting background. Further observation revealed the egress doors at the back of the B hall did not have delayed egress signage and the back exit of A hall had the delayed egress signage blocked by the push bar.</p> <p>Interview, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed the doors were unlocked all of the time unless someone with a wander guard was near the door so he did not think the delayed egress signage was required.</p> <p>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. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock</p>	K 038	<p>the requirements regarding delayed egress signage.</p> <p>4. The Maintenance Director will audit exit doors monthly for three (3) months to ensure signage meets requirements. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>		

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K 038	Continued From page 9 such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling	K 038		

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K 038	Continued From page 10 the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 047 SS=D	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047	K 047 – Life Safety Code 1. Exit signage will be posted at the two (2) laundry doors stating they are not approved exits. This will be completed by the Maintenance Director by 7/28/13. The exit	7/29/13

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K 047	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure no exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure two (2) doors leading to the outside of the laundry were marked with proper no exit signs and the two (2) exit signs were properly illuminated The findings include: Observation, on 06/12/13 at 12:18 PM with the Maintenance Director, revealed (2) doors leading to the outside of the laundry that were not approved exits. The two (2) doors did not have any signage stating whether the doors were exits or not exits. Interview, on 06/12/13 at 12:18 PM with the Maintenance Director, revealed the two (2) doors were not part of the evacuation plan and was unaware they should be properly marked with no exit signage. Observation, on 06/12/13 at 12:18 PM with the Maintenance Director, revealed the exit signs located in the laundry area were not illuminated. Interview, on 06/12/13 at 12:18 PM with the Maintenance Director, revealed he was not aware the exit signs in the facility were required to be	K 047	signs located in the laundry area will be illuminated. This will be completed by 7/28/13 by the Maintenance Director. 2. All doors leading to the outside of the facility will be audited by the Maintenance Director by 7/28/13 to ensure there is signage stating whether the doors are exits or not exits and that exit signs are illuminated. Any doors identified as not having proper signage or illuminated will be corrected immediately. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on proper signage and illumination of all doors leading to the outside of the facility. 4. The Maintenance Director will audit all doors leading to the outside of the facility monthly for three (3) months to ensure proper signage and illumination. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	

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K 047	<p>Continued From page 12 Illuminated.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.10.8 Special Signs. 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.</p> <p>7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light</p>	K 047		

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K 047	Continued From page 13	K 047		
K 051 SS=F	<p>source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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, 9.8</p> <p>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</p>	K 051	<p>K 051 – Life Safety Code</p> <ol style="list-style-type: none"> 1. The manual fire alarm pull stations located at the side exit and on A Hall behind the cross corridor doors will be moved to the proper height. This will be completed by a vendor as directed by the Maintenance Director by 7/28/13. 2. All other manual fire alarm pull stations will be measured by the Maintenance Director by 7/10/13 to ensure they are at the proper height. Any that are identified as not being at proper height will be moved to the proper height by a vendor as directed by the Maintenance Director by 7/28/13. 3. The Maintenance Director will be re-educated by the Administrator by 7/29/13 on the proper mounting height of manual fire alarm pull stations. 4. The Maintenance Director will audit the manual fire alarm pull stations monthly for three (3) months to ensure they are mounted at the proper height. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, 	7/29/13

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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1661 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 051	Continued From page 14 required by NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure two (2) fire alarm manual boxes were not mounted over 4-1/2' from the floor. The findings include: Observation, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed the manual fire alarm pull stations were mounted over 4-1/2 feet from the finished floor located at the side exit and on A hall behind the cross-corridor doors. Interview, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed he was unaware of the required heights of the manual pull stations for the fire alarm. Reference: NFPA 72 (1999 Edition). 2-8.1 Mounting. Each manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 31/2 feet (1.1 m) and not more than 41/2 feet (1.37 m) above floor level.	K 051	Social Services Director with the Medical Director attending at least quarterly.	
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	K 056	K 056 - Life Safety Code 1. The ceiling fan will be removed by the Maintenance Director by 7/10/13. The standard response sprinkler heads in room	7/29/13

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K 056	<p>Continued From page 15</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure one (1) sprinkler head was not blocked by fixtures on the ceiling and that all sprinkler heads matched in a compartment.</p> <p>The findings include:</p> <p>Observations, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed the sprinkler head located at the B hall nurses' station was blocked by a ceiling fan within 1 foot of the sprinkler head, extending below the sprinkler heads.</p> <p>Interview, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed</p>	K 056	<p>#5 and in the television/dining area will be replaced with quick response sprinkler heads by 7/28/13. This will be completed by a vendor under the direction on the Maintenance Director.</p> <p>2. The Maintenance Director will audit all other compartments to ensure that all sprinkler heads match in that compartment and are unobstructed. Any compartments identified as having sprinkler heads that do not match or are obstructed will be corrected by 7/28/13 by a vendor under the direction of the Maintenance Director.</p> <p>3. The Maintenance Director will be re-educated by the Administrator on the requirement that all sprinkler heads in a compartment must be matching sprinkler heads and all sprinkler heads must be unobstructed.</p> <p>4. The Maintenance Director will complete an audit of all sprinkler heads in each compartment to ensure they match and are unobstructed. This will be done monthly for three (3) months. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>	

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K 056	<p>Continued From page 16</p> <p>the facility had done a recent audit and changed several light fixtures to be in compliance but they must have overlooked the one at the nurses' station.</p> <p>Observations, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed a standard response sprinkler head and quick response sprinkler head in the same compartment located in resident room #5 and in the television/dining room area.</p> <p>Interview, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed he was unaware of the mixed response sprinkler heads in the facility.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Maximum Allowable Distance</td> </tr> <tr> <td>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td style="text-align: center;">of Deflector Obstruction (in.)</td> </tr> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td style="text-align: center;">0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td style="text-align: center;">2 1/2</td> </tr> </table>		Maximum Allowable Distance	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	K 056		
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K 056	<p>Continued From page 17</p> <table border="0"> <tr><td>1 ft 6 in. to less than 2 ft</td><td>31/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>51/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>71/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>91/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>161/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same 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 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.</p>	1 ft 6 in. to less than 2 ft	31/2	2 ft to less than 2 ft 6 in.	51/2	2 ft 6 in. to less than 3 ft	71/2	3 ft to less than 3 ft 6 in.	91/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	161/2	5 ft and greater	18	K 056		
1 ft 6 in. to less than 2 ft	31/2																			
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K 056	Continued From page 16 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 056		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure four (4) sprinkler heads were maintained in reliable operating condition. The findings include: Observations, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed the sprinkler head located in the freezer, housekeeping closet, and central supply had	K 062	K 062 – Life Safety Code 1. The sprinkler heads located in the freezer, housekeeping closet and central supply will be replaced by a vendor under the direction of the Maintenance Director by 7/28/13. The paint will be removed from the sprinkler head located in resident room #9. This will be completed by the Maintenance Director by 7/28/13. 2. All other sprinkler heads in the facility will be inspected by the Maintenance Director by 7/28/13 to ensure they are not corroded or painted. Any sprinkler heads identified as being corroded will be replaced by a vendor under the direction of the Maintenance Director by 7/28/13. Any sprinkler heads identified as being painted will have the paint removed by the Maintenance Director by 7/28/13. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on ensuring sprinkler heads are not painted or corroded.	7/29/13

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K 062	Continued From page 19 corrosion build up on the sprinkler head. Further observation revealed a painted sprinkler head located in resident room #9 Interview, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed he was unaware of the corrosion and paint located on the sprinkler heads. Reference: NFPA 25 (1998 Edition). 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.	K 062	4. The Maintenance Director will complete a monthly audit for three (3) months on all sprinkler heads to ensure they are not painted or corroded. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	
K 066 SS=D	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. (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	K 066	K 066 – Life Safety Code 1. The cigarette butts on the ground in the mulch area around the concrete patio at the front porch area were picked up on 6/17/13 by the Maintenance Director. 2. The grounds around the facility was free from cigarette butts as observed by the Maintenance Director on 6/17/13. 3. All staff will be re-educated by the Administrator, Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 on keeping cigarette butts off the grounds.	7/29/13

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K 066	<p>Continued From page 20 permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays at an entrance, 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-Three (53) on the day of the survey. The facility failed to ensure ashtrays were properly utilized at the smoking area on the front porch.</p> <p>The findings include:</p> <p>Observation, on 06/12/13 at 12:14 PM with the Maintenance Director, revealed the smoking area at the front porch of the facility had over one dozen cigarette butts on the ground in the mulch area around the concrete patio.</p> <p>Interview, on 06/12/13 at 12:14 PM with the Maintenance Director, revealed he has to consistently clean the area of cigarette butts due to them being on the ground.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 066	<p>4. The Maintenance Director will audit the facility grounds weekly for twelve (12) weeks to ensure the grounds are free of cigarette butts. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>	

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K 066	Continued From page 21 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	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	K 069	K 069 - Life Safety Code 1. The wall mounted manual pull for the hood suppression system will be relocated to	7/29/13

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K 069	Continued From page 22 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, four (4) residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the manual pull for the kitchen hood suppression system was located in a egress path. Findings Include: Observations, on 06/12/13 at 12:18 PM with the Maintenance Director, revealed the wall mounted manual pull for the hood suppression system was located in the dishwashing area and not in the egress path to exit the kitchen. Interview, on 06/12/13 at 12:18 PM with the Maintenance Director, revealed he was unaware the manual pull was required to be mounted in the egress path. Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the	K 069	an area in the egress path to exit the kitchen. This will be completed by a vendor under the direction of the Maintenance Director by 7/28/13. 2. There were no other pull stations in the facility affected by this practice as observed by the Maintenance Director on 7/1/13. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on the requirements related to the location of wall mounted manual pull stations. 4. The Maintenance Director will audit manual pull stations monthly for three (3) months to ensure they are mounted in an egress path. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	

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PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2013
NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104	
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K 069	Continued From page 23 other.	K 069		
K 072 SS=E	<p>Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link.</p> <p>Exception No. 2: An automatic sprinkler system.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>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 two (2) of four (4) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the exit corridor at the front exit was kept free and clear of impediments.</p> <p>The findings include:</p> <p>Observation, on 06/12/13 at 12:18 PM with the Maintenance Director, revealed two (2) couches, a piano, a table, a plant, a bookcase, and two (2) dining tables located in the egress path to the front exit of the building.</p>	K 072	<p>K 072 – Life Safety Code</p> <ol style="list-style-type: none"> 1. The Maintenance Director contacted the State Fire Marshall to review our evacuation route. He visited the facility and will be providing written approval of our new evacuation route. The Maintenance Director will change our posted evacuation route to the B Hall side exit and will be posting signage on the front lobby door indicating it is not an emergency exit. This will be completed by 7/28/13. 2. The Maintenance Director completed an audit of all egresses on 6/17/13. All egresses were clear of impediments. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on keeping egress paths clear of impediments. 4. The Maintenance Director will complete an audit monthly for three (3) months to ensure egress paths are clear of impediments. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance 	7/29/13

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K 072	Continued From page 24 Interview, on 06/12/13 at 12:18 PM with the Maintenance Director, revealed the facility had the area set up as the television viewing area and previously there was a knock down wall that separated the corridor from the rest of the area. 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	Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	
K 073 SS=E	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 and interview, it was determined the facility failed to ensure that no combustible furnishings were used in the facility, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure seven (7) upholstered chairs brought into the facility were being properly protected by a smoke detector.	K 073	K 073 – Life Safety Code 1. The Maintenance Director will install smoke detectors in rooms #34, 32, 25, 26, 10, 14 and 17 by 7/28/13. 2. All rooms will be audited by the Maintenance Director to ensure no other rooms have upholstered chairs without smoke detectors. Any rooms identified will have smoke detectors installed by 7/28/13. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on ensuring that rooms that have upholstered chairs have smoke detectors installed in the rooms. 4. The Maintenance Director will audit all residents rooms monthly for three (3) months to ensure any rooms with upholstered chairs have smoke detectors installed. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations	7/29/13
	The findings include: Observation, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed			

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K 073	Continued From page 25 upholstered chairs brought into the facility from the resident homes located in rooms #34, 32, 25, 26, 10, 14, and 17. Interview, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed he was unaware of the requirement to have a single-station smoke detector located in the resident room if there is an upholstered chair brought from home. Further interview revealed all the resident rooms had smoke detectors but he had told to remove them from the facility. Reference: NFPA 101 (2000 Edition) 19.7.5.2 Newly introduced upholstered furniture within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(2) and 10.3.3. Exception: Upholstered furniture belonging to the patient in sleeping rooms of nursing homes, provided that a smoke detector is installed in such rooms. Battery-powered single-station smoke detectors shall be permitted.	K 073	as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.	K 104	K 104 – Life Safety Code 1. The fire/smoke damper testing was completed on 7/24/13 by Universal Equipment Services. 2. The fire/smoke damper testing was completed on 7/24/13 by Universal Equipment Services.	7/29/13

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K 104	Continued From page 26 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure smoke dampers in the hvac system were being inspected. The findings include: Life Safety Record Review, on 06/12/13 at 1:40 PM with the Maintenance Director, revealed no documentation for fire/smoke damper testing. Interview, on 06/12/13 at 1:40 PM with the Maintenance Director, revealed that no maintenance documentation was kept on the fire/smoke dampers. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104	3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on the requirement to have documented fire/smoke damper testing. 4. The Maintenance Director will complete a monthly audit for three (3) months to ensure fire/smoke damper testing is complete and documented. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	K 130 - Life Safety Code 1. Protective poles will be installed in front of the gas main by a vendor under the	7/29/13

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K 130	Continued From page 27 This STANDARD is not met as evidenced by: Based on observation and interview, 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-six (36) residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the gas main was properly protected from equipment. The findings include: Observation, on 06/12/13 at 1:40 PM with the Maintenance Director, revealed there was no protection against physical damage to the gas main located the side exit. There is a parking curb but large equipment could extend over the curb and damage the gas main. Interview, on 06/12/13 at 1:40 PM with the Maintenance Director, revealed he was not aware the gas main needed to have more protection than a parking curb. Reference: NFPA 101 (2000 Edition) Gas meters, regulators and piping must be protected against physical damage in an approved manner when exposed to equipment traffic. The barriers must be designed to the largest piece of equipment that would be typically parked or used in the immediate area.	K 130	direction of the Maintenance Director by 7/28/13. 2. A complete observation of the facility by the Maintenance Director on 7/1/13 revealed no other areas affected by this practice. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on protecting gas meters, regulators and piping against physical damage. 4. The Maintenance Director will complete a monthly audit for three (3) months to ensure all gas meters, regulators and piping are protected against physical damage. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	

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K 130 K 143 SS=E	Continued From page 28 NFPA 54, National Fuel Gas Code NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the oxygen transferring room had a fire rated door and frame that had a 1	K 130 K 143	K 143 – Life Safety Code. 1. The oxygen trans-filling room door and frame will be replaced with a door and frame that has a one-hour fire rating. This will be completed by a vendor under the direction of the Maintenance Director by 7/28/13. 2. The facility has no other oxygen trans-filling rooms. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on the requirements related to having a one-hour fire rated door and frame on the oxygen trans-filling room. 4. The Maintenance Director will complete a monthly audit for three (3) months to ensure the oxygen trans-filling room is properly protected by a one-hour fire rated door and frame. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	7/29/13	

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K 143	<p>Continued From page 29 hour fire resistive rating.</p> <p>The findings include:</p> <p>Observation, on 06/12/13 at 1:50 PM with the Maintenance Director, revealed the oxygen trans-filling room did not have a one-hour fire rated door and frame installed.</p> <p>Interview, on 06/12/13 at 1:50 PM with the Maintenance Director, revealed he was unaware of the requirement to have a rated door and frame on an oxygen trans-filling room.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <ul style="list-style-type: none"> a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. <p>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.</p>	K 143		

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K 143	Continued From page 30 The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the emergency generator according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure there was battery backup lighting at the generator transfer switch. The findings include: Observation, on 06/12/13 at 2:03 PM with the Maintenance Director, revealed the facility did not have any battery-powered lighting installed in the area where the transfer switch for the emergency	K 144	K 144 – Life Safety Code 1. Battery-powered lighting will be installed in the area where the transfer switch for the emergency generator is located. This will be completed by a vendor under the direction of the Maintenance Director by 7/28/13. 2. A complete observation of the facility by the Maintenance Director on 6/28/13 revealed no other areas affected by this practice. 3. The Maintenance Director will be re-educated by the Administrator by 7/28/13 on battery-powered lighting being installed in the area where the transfer switch for the emergency generator is located and the testing requirements for this lighting. 4. The Maintenance Director will complete a monthly audit on battery-powered lighting and testing. This will be completed monthly for three (3) months. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of a	7/29/13

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K 144	Continued From page 31 generator was located. Interview, on 06/12/13 at 2:03 PM with the Maintenance Director, revealed he was not aware of the requirement for the battery backup lighting in the transfer switch room. Reference: NFPA 110 (1999 Edition). 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.	K 144	minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	
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 two (2) of four (4) smoke compartments, fifty-three (53) residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure power strips	K 147	K 147 – Life Safety Code 1. The mini-nebulizers in rooms #5 and #23 were unplugged from the power strips by the Maintenance Director by 6/17/13. The extension cord in room #5 was removed by the Maintenance Director by 6/17/13. The air mattress in room #14 was unplugged from the power strip and plugged in to a wall outlet by the Maintenance Director by 6/17/13. 2. The Maintenance Director completed an inspection of all resident rooms on 6/17/13 to ensure no other medical equipment was plugged in to power strips and no extension cords were in use. No other areas were identified. 3. All staff will be re-educated that no extension cords be used in the facility and	7/29/13

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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1661 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	<p>Continued From page 32 were being used properly.</p> <p>The findings include:</p> <p>Observations, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed:</p> <ol style="list-style-type: none"> 1) A mini-nebulizer was plugged into a power strip located in room #23. 2) An extension cord was plugged into a fan located in room #5. 3) An air mattress was plugged into a power strip located in room #14. 4) A mini-nebulizer was plugged into a power strip located in room #5. <p>Interview, on 06/12/13 between 12:13 PM and 3:30 PM with the Maintenance Director, revealed he was unaware of the items being improperly plugged into power strips and the one (1) extension cord in use.</p> <p>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.</p> <p>Reference: NFPA 70 (1999 Edition). 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p>	K 147	<p>no medical equipment is to be plugged in to power strips. This will be completed by the Administrator, Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13.</p> <p>4. The Maintenance Director will complete an audit of all resident's rooms monthly for three (3) months to ensure no extension cords are in use and no medical equipment is plugged in to power strips. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

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K 147	Continued From page 33 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code. Actual NFPA Standard: NFPA 70, Article 400-8. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used as a substitute for the fixed wiring of a structure. CMS Manual System, Pub. 100-07 State Operations, Provider Certification; August 17, 2007. Power strips may not be used as a substitute for adequate electrical outlets in a facility. Power strips may be used for a computer, monitor, and printer. Power strips are not designed to be used with medical devices in patient care areas. Precautions needed if power strips are used include: installing internal ground fault and over-current protection devices; preventing cords from becoming tripping hazards; and using power strips that are adequate for the number and types of devices used. Overload on any circuit can potentially cause overheating and fire. The use of ground fault circuit interruption (GFCIs) may be required in locations near water sources to prevent electrocution of staff or	K 147		

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K 147	Continued From page 34 residents.	K 147		