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

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FORM APPROVED
OMB NO. 0938-0391

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

RECEIVED
APR 2014
OFFICE OF INSPECTOR GENERAL

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1962. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (200). SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1962, with 21 smoke detectors and no heat detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1962 and upgraded in 2010. GENERATOR: Type II generator installed in 2011. Fuel source is Natural Gas. An Abbreviated Life Safety Code Survey investigating #KY 21330 was initiated on 02/18/14 with a Standard Life Safety Code Survey. Both surveys were concluded on 02/20/14. Bowling Green Nursing and Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The complaint was found to be substantiated with deficiencies cited. The facility is certified for sixty-six (66) beds with a census of fifty-seven	K 000	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 (10) days of the survey as a condition to participate in Title18, 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David [illegible], Adm	Administrator	4-17-14

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

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K 000	Continued From page 1 (57) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at a Scope and Severity of an "F". Repeat Deficiencies: The following are repeat deficiencies from the standard survey conducted on 06/12/13: K-25, 29, 38, 47, 62, 66, 69, 72, 73, and 147.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K 018 1. Doors for rooms #1, 7, 28 and #4 have been ordered through as one hour fire-rated doors to resist the passage of smoke. Doors will be installed by on 3/28/14 2. An audit of all doors to resist the passage of smoke was conducted throughout the facility completed on 3/14/14 to validate NFPA standards. The result of all doors on indicated the rooms that have been ordered. 3. Regional Facilities Director will educate Maintenance Director and Administrator to enforce NFPA standards by 3/28/14	3/31/14

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, eight (8) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The findings include: Observation, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed the corridor doors to rooms #7 and #28 had a gap greater than one half (1/2)inch from the door stop and would not resist the passage of smoke. Further observation revealed the corridor doors to rooms #1 and #4 would not latch when tested. Interview, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed he was not aware the doors identified had too large of a gap or would not latch to resist the passage of smoke. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for door gaps or doors latching. Further interview revealed he was aware of the requirements for doors in the corridor; however, he was not aware the doors identified had too	K 018	4. The Maintenance Director or Administrator will audit 5 doors monthly for three months and report any deficiency findings to the Quality Assurance Committee monthly for three months until the matter is considered in compliance. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	

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K 018	Continued From page 3 large of a gap or would not latch to resist the passage of smoke. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved	K 018		

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K 018	Continued From page 4 automatic sprinkler system in accordance with NFPA standards.	K 018		3/31/14
K 025 SS=F	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, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The findings include: Observations, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed the smoke barrier extending above the ceiling located in the A-Hall by room #11 did not extend to the roof sheathing.	K 025	1. The smoke barrier above room #11 has been extended to the roof sheathing. The work was completed on 3/14/14 On B-Hall by room #35, the smoke partitions will be sealed with approved sealant by 3/28/14. 2. The attic was audit for any deficiencies and none was found on 3/14/14. The attic is up to NFPA standards. 3. All future work in the attic by the Maintenance Director or outside contractor will be required to seal all penetrations to the smoke barrier immediately following the penetrations with the appropriate rated sealant. The Regional Facilities Director will educate Maintenance Director on proper sealant for smoke barriers according to NFPA standards by 3/28/14 4. Audits will be conducted monthly or when construction is taken place. The Director of Maintenance or Administrator will report any deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. . The Quality	

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K 025	Continued From page 5 The wall was not sealed to the roof sheathing and could not resist the passage of smoke. Further observation revealed the smoke partition located in the B-Hall by room #35 had drywall mud over quick foam in a concrete block wall. Sealant must be rated or equal to the wall. Interview, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director revealed he was not aware of the penetrations or the unrated sealant. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for smoke barriers. Further interview revealed he was aware of the requirements for smoke barriers; however, he was not aware of the penetrations or the unrated sealant. Reference: NFPA 101 (2000 Edition). 8.3 SMOKE BARRIERS 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall	K 025	Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	

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K 025	Continued From page 6 not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier. Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 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. (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	K 025		

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K 025	Continued From page 7 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.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to maintain	K 029	K 029 1. On 2/19/14 the Administrator noted the hazardous door next to the conference room was not propped open. 2. On 2/19/14 the Administrator observed that there were no doors propped open to hazardous areas. 3. All staff will be educated by Administrator, DON, ADON or Maintenance Director on not to prop doors open with any materials and keep egress doors clear by 3/28/14. 4. Audit will be conducted by Maintenance Director or Administrator to ensure egress doors and self closings are not blocked with any materials once a week for three months The results of these audits will be reviewed with the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality	3/31/14

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K 029	Continued From page 8 self-closing doors protecting hazardous areas. The findings include: Observation, on 02/18/14 at 11:13 AM, with the Maintenance Director from a sister facility revealed the door to a hazardous room located next to the Conference Room had a self-closing device installed to keep the door closed; however, the door was held open with a book-end and a paint can leaving the room open to the egress corridor. Interview, on 02/18/14 at 11:13 AM, with the Maintenance Director revealed contractors working on the building had held the door open and they were not aware of the requirements for protection from hazards. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed he was not aware the door had been held open. Further interview revealed he was not aware of a policy for self-closing doors on hazardous rooms. Reference: NFPA 101 (2000 Edition). 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	K 029	Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	

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K 029	Continued From page 9 from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 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	K 038	K 038 1. New locks that allow proper delayed egress and released when fire alarm is activated will be complete by 3/28/14. On 3/17/14 the three identified exit doors had signage placed that was at least one inch tall. 2. The Maintenance Director was educated by the administrator on or by 3/14/14 regarding ensuring delayed egress doors and exits were	3/31/14

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K 038	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure doors with delayed egress locks were operational and had proper signage. The findings include: Observation, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed the exit door located in the B-Hall was equipped with a delayed egress lock that failed to release when tested. The door would release with the fire alarm and with the keypad. Random staff members were asked to open the door with a 100% success rate; however, the code was not posted. Interview, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed he was not aware the delayed egress door was not functioning properly. Observation, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed the delayed egress signage on three (3) of three (3) exit doors did not have letters that were one (1) inch tall. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for delayed egress doors. Further interview	K 038	maintained in accordance with NFPA standards. 3. Starting the week of 3/17/14, the Maintenance Director or Administrator will complete audits weekly for 8 weeks an then monthly for two months to ensure proper release of doors in the facility. The Maintenance Director will be educated by the Administrator by 3/28/14 regarding ensuring delayed egress doors and exits were maintained in accordance with NFPA standards. 4. The Maintenance Director or Administrator will complete audits weekly for 8 weeks and then monthly for two months to ensure proper release of doors in the facility. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly	

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K 038	Continued From page 11 revealed the delayed egress doors were checked weekly; however, he was not aware the delayed egress door was not functioning properly. Reference: NFPA 101 (2000 edition) 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 the lock or locking mechanism. (c) An irreversible process shall release the lock	K 038		

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K 038	Continued From page 12 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 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.	K 038		

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K 038	Continued From page 13 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings. Reference: NFPA 101 (2000 edition) 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. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.	K 038		

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K 038	Continued From page 14 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. Reference: CMS S&C letter 5-38 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.	K 038		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on interview and battery light testing record review, it was determined the facility failed to provide emergency lighting in accordance with	K 046	K-046 1. The facility will install new up to date emergency lighting throughout by 3/28/14. 2. An audit on 3/14/14 of all emergency lighting was conducted to ensure compliance with NFPA standards. No concerns were identified. 3. The Maintenance Director or Administrator will test the emergency lighting for a minimum duration of (30) thirty seconds monthly and 11/2 hour annually. This will be in accordance with the facility TELS program with battery back-up located at the transfer switch and the generator. Education of the Maintenance Director by the Administrator to audit proper emergency lighting by 3/28/14. 4. The Maintenance Director or Administrator will audit to ensure compliance of emergency lighting on a monthly basis for three months. The Maintenance Director or Administrator will monitor for deficiency findings and report findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of Nursing, Administrator, ADON, DON, Dietary Director, Maintenance Director, Social Services Director, and Activities Director with the Medical Director at least Quarterly.	3/31/14

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K 046	Continued From page 15 NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure they conducted monthly and annual emergency battery light testing for the minimum duration requirement of Emergency lighting for at least thirty (30) seconds monthly and 1-1/2 hour annually. The findings include: Emergency battery light testing record review, on 02/20/14 at 9:00 AM with the Administrator revealed the facility failed to test the emergency lights, with battery backup, located at the transfer switch and the generator for thirty (30) seconds monthly or 1-1/2 hours annually. Interview, on 02/20/14 at 9:00 AM, with the Administrator revealed he was not aware the lighting had to be tested for thirty (30) seconds monthly or 1-1/2 hours annually. Further interview revealed the facility did not have a policy for the testing of battery lights; however it was listed in the TELS program for monthly checks. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at	K 046		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 046	Continued From page 16 floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 1. Exit signs and directional signs were installed in the kitchen on 2/24/14 Non -Exit signs will be installed at the front door to be completed on 03/28/2014. 2. The Maintenance Director or Administrator will inspect all exits in the building for proper signage by	3/31/14

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K 047	Continued From page 17 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, and Kitchen Staff. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The findings include: Observation, on 02/18/13 at 1:40 PM, with the Maintenance Director from a sister facility. revealed the front door did not have signage to indicate if it was an Exit or No Exit. Review of the Plan of Correction from the previous survey revealed the front door had been removed from the egress path in the event of an emergency. Interview, on 02/18/13 at 1:40 PM, with the Maintenance Director revealed he was not aware the front door did not have the proper signage. Observation, on 02/19/13 at 10:20 AM, with the Maintenance Director revealed the kitchen did not have proper exit signage to make the path of egress clearly recognizable. Interview, on 02/19/13 at 10:20 AM, with the Maintenance Director revealed he was not aware the kitchen did not have proper exit signage. Interview, on 02/20/13 at 1:30 PM, with the Administrator revealed the facility did not have a policy for exit signage. Further interview revealed he was not aware the kitchen or the front door did not have proper exit signage.	K 047	3/28/14 any identified concerns will be corrected by 03/28/14. 3. Education of the Maintenance Director by the Administrator to audit proper Exit and Non-exit signs by 3/28/14. 4. The Maintenance Director or Administrator will inspect monthly for three months all exit doors for proper signs and ensure signs are maintained. The Maintenance Director or Administrator will present audit findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly	

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K 047	Continued From page 18 Reference: NFPA 101 (2000 edition) 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons. 7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 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. 7.10.1.3 Exit Stair Door Tactile Signage. Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows: EXIT Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the centerline of the sign. Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change. 7.10.1.4* Exit Access. Access to exits shall be marked by approved,	K 047		

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K 047	Continued From page 19 readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. 7.10.1.5* Floor Proximity Exit Signs. Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame. 7.10.1.6* Floor Proximity Egress Path Marking. Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. 7.10.1.7* Visibility.	K 047		

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Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted.
7.10.2* Directional Signs.
A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent.
7.10.3* Sign Legend.
Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters.
7.10.4* Power Source.
Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration.
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 source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.

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K 047	Continued From page 21 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.6 Externally Illuminated Signs. 7.10.6.1* Size of Signs. Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height. Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high. Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5. 7.10.6.2* Size and Location of Directional Indicator. The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and	K 047		

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K 047	Continued From page 22 stroke. The directional indicator shall be located at the end of the sign for the direction indicated. Exception: This requirement shall not apply to approved existing signs. Figure 7.10.6.2 Chevron-type indicator. 7.10.6.3* Level of Illumination. Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5. 7.10.7 Internally Illuminated Signs. 7.10.7.1 Listing. Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment. Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5. 7.10.7.2* Photoluminescent Signs. The face of a photoluminescent sign shall be continually illuminated while the building is occupied. The illumination levels on the face of the photoluminescent sign shall be in accordance with its listing. The charging illumination shall be a reliable light source as determined by the authority having jurisdiction. The charging light source shall be of a type specified in the product markings. 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:	K 047		

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K 047	Continued From page 23 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. 7.10.8.2 Elevator Signs. Elevators that are a part of a means of egress (see 7.2.13.1) shall have the following signs, with minimum letter height of 5/8 in. (1.6 cm), in every elevator lobby: (1) * Signs that indicate that the elevator can be used for egress, including any restrictions on use (2) * Signs that indicate the operational status of elevators 7.10.9 Testing and Maintenance. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days. 7.10.9.2 Testing. Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 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. Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual	K 047		

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

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

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

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K 047	Continued From page 24 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 other. 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. Exception No. 2: An automatic sprinkler system.	K 047		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments,	K 050	K 050 1. The Maintenance Director or Administrator will schedule and document fire drills at unexpected random times and 2 hours apart from previous quarter drills this schedule was reviewed by the Administrator on 03/14/14 2. The Maintenance Director or Administrator will schedule and document fire drills at unexpected random times and 2 hours apart from previous quarter drills this schedule was reviewed by the Administrator on 03/14/14 3. The Administrator will educate maintenance director on fire drills to be schedule randomly including weekends by 3/28/14.	3/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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K 050	Continued From page 25 sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly on each shift at unexpected times. The findings include: Fire Drill record review, on 02/20/14 at 9:00 AM, with the Administrator revealed the facility failed to conduct quarterly fire drills for each shift at random times. The facility has three (3) shifts that work Monday-Friday and weekend staff that work three (3) shifts Saturday and Sunday. The Monday-Friday third shift fire drills were not being conducted at random times. The weekend staff (Saturday and Sunday) did not conduct quarterly fire drills for all three (3) shifts. Only three (3) fire drills were conducted on the weekend between 06/02/13 and 12/07/13 for the three (3) shifts. Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy to detail when to conduct fire drills. Further interview revealed the Maintenance Director was responsible for conducting the fire drills. Further interview revealed he was aware of the requirements for fire drills; however, he was not aware the fire drills were not being conducted in accordance with NFPA standards. Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	4. The Maintenance Director or Administrator will conduct fire drills on each shift and reports will be reviewed monthly for three months and then quarterly. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	