

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

PRINTED: 04/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185317</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELLE MEADE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>521 GREENE DR. GREENVILLE, KY 42345</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A standard recertification survey was conducted on 12/11/12 through 12/13/12 to determine the facility's compliance with Federal requirements. The facility was found to meet minimum Federal requirements with no deficiencies cited.	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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

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

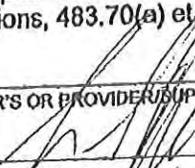
PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345	
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1965.</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 1965, with 35 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965.</p> <p>GENERATOR: Type II generator installed in 2008. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/12/2012. Belle Meade Home was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty-Two (62) 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 Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>Preparation and/or execution of the Plan of Correction does not constitute admission or agreement to the alleged cited deficiencies.</p> <p>Belle Meade Home submits this Plan of Correction as evidence of adherence to state and federal requirements for licensure and participation in the Medicare and Medicaid programs.</p> <p>This document is not intended to waive any defense, legal or equitable, in administrative, civil, or criminal proceedings.</p> <p>Sprinkler System installed in 1980</p>	

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

TITLE

(X6) DATE



*Adm.*

*1-23-13*

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.

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345		
(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  K 025 SS=F	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure three (3) smoke barriers were sealed around wires and through pipes extending through the smoke barriers. This deficiency was cited on the survey last year on 08/30/11.</p> <p>The findings include:</p>	K 000  K 025	<p>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>-No residents were affected by the deficient practice. The three sited smoke barriers will be sealed with a material capable of maintaining the smoke resistance of the smoke barrier, "Flame Stopper 5000" The projected completion date is 1-31-13.</p> <p>How will this facility identify other Residents having the potential to be Affected by the same deficient practices?</p> <p>-All residents had the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>-Smoke barriers added to the weekly Environmental Safety Report.</p> <p>How will this facility plan to monitor its performance to ensure that solutions are maintained?</p>	2-1-13

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345		
(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	<p>Continued From page 2</p> <p>Observations, on 12/12/12 between 10:30 AM and 11:10 AM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling, located throughout the facility except the one located next to room #200 were penetrated by pipes and wires.</p> <p>Interview, on 12/12/12 between 10:30 AM and 11:10 AM with the Maintenance Supervisor, revealed he was unaware of the penetrations in the smoke barriers.</p> <p>Interview, on 12/12/12 at 3:00 PM with the Administrator, revealed he was unaware of the penetrations in the smoke barriers. The facility followed the plan of correction conducting a wall inspection four times a month. He was very confused as to how there were penetrations in the smoke barriers because there was such an emphasis on this particular life safety code. He relied on the Maintenance Supervisor and the Maintenance Personal to ensure the smoke barriers were sealed from penetrations.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <p>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</p>	K 025	<p>-The Safety Team shall monitor the Environmental Safety Supervisor for six months and resume yearly review after no further deficient practices are identified. The Environmental Safety Supervisor shall complete a weekly safety check of all smoke barrier devices and maintain them in compliance to the regulated standard. The Safety Team shall report to the Quality Assurance team quarterly. The facility is alleging a projected compliance date of 1-31-13.</p>	

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345		
(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 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 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 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-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 latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure access doors in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, thirty-four (34) residents,	K 027	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  -No residents were affected by the deficient practice. The two smoke barrier access doors shall be replaced with two smoke barrier doors that have fire resistance ratings of not less than ½ hour. The projected date of completion is 1-31-13.  How will this facility identify other residents having the potential to be affected by the same deficient practices?  -All residents had the potential to be affected by the deficient practice.	2-1-13	

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345	
(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 027	Continued From page 4 staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the attic doors in the smoke barriers were not homemade.  The findings include:  Observation, on 12/12/12 at 10:32 AM with the Maintenance Supervisor, revealed two (2) unrated homemade smoke barrier access doors located in the smoke barriers next to rooms # 234 and 218.  Interview, on 12/12/12 at 10:32 AM with the Maintenance Supervisor, revealed he was not aware the doors in the attic must be rated for use.  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.  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. NFPA 101 LIFE SAFETY CODE STANDARD	K 027	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  -Smoke barrier access doors added to the weekly Environmental Safety report.  How will this facility plan to monitor its performance to ensure that solutions are maintained?  -The Safety Team shall monitor the Environmental Safety Supervisor for six months and resume yearly evaluations after no further deficient practices are identified. The Environmental Safety Supervisor shall complete a weekly Safety check of all smoke barrier devices and maintain them in compliance with the regulated standard. The facility is alleging a projected date of compliance on 1-31-13.	
K 029 SS=D	One hour fire rated construction (with 3/4 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	K 029	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  -No residents were affected by the deficient practice. Door Closers were added to the three sited doors on 12-27-27.	1-11-13

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42346		
(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 029	Continued From page 5 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, no residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure three (3) rooms were properly protected due to the storage in the rooms.  The findings include:  Observation, on 12/12/12 between 12:58 PM and 2:45 PM with the Maintenance Supervisor, revealed the Assistant Director of Nursing office, the Royal Manor Office, and the storage room in the therapy office did not have a closer added to the door. This requirement is due to the storage of combustible items inside the areas.  Interview, on 12/12/12 between 12:58 PM and 2:45 PM with the Maintenance Supervisor, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.	K 029	How will this facility identify other residents having the potential to be affected by the same deficient practices?  -All residents had the potential to be affected by the deficient practice.  What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  -Fire barriers added to the Environmental Safety Rounds weekly report.  How will this facility plan to monitor its performance to ensure that solutions are maintained?  The Safety Team shall monitor the Environmental Safety Weekly reports and report to the Quality Assurance Team Quarterly for one year. On 1-10-13 Safety Rounds were completed by the Administrator, Director of Nurses and the Quality Assurance Coordinator to ensure that the sited deficient practice was corrected. The facility is alleging compliance on 1-10-13.		

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345	
(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 029	Continued From page 6  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 from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345		
(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 038	<p>Continued From page 7</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, no residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure two (2) exits had a durable surface to the public way.</p> <p>The findings include:</p> <p>Observation, on 12/12/12 between 11:25 AM and 2:45 PM with the Maintenance Supervisor, revealed the Julian Sparks corridor does not have a 4' wide durable surface to a public way. Further observation revealed the Garden exit did not have a 4' wide durable surface to a public way.</p> <p>Interview, on 12/12/12 between 11:25 AM and 2:45 PM with the Maintenance Supervisor, revealed he was unaware exits require a durable path to the public way.</p>	K 038	<p>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>-No residents were affected by the deficient practice. The two sited locations were designated "Not An Exit" with signage on 12-27-12. See Photos #1 &amp; #2</p> <p>How will this facility identify other residents having the potential to be affected by the same deficient practices?</p> <p>-All residents had the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>-Signage added to Environmental Safety weekly rounds check.</p> <p>How will this facility plan to monitor its performance to ensure that solutions are maintained?</p>	1-11-13	

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
(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 038	Continued From page 8 Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1.  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. 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.  CMS S&C letter 5-38 NFPA 101 LIFE SAFETY CODE STANDARD	K 038	-The Safety Team shall monitor the Environmental Safety Weekly Reports and report to the Quality Assurance Team Quarterly for one year. On 1-10-13 Safety Rounds were made by the Administrator, Director of Nurses and the Quality Assurance Coordinator to ensure that the sited deficient practice was corrected. The facility is alleging compliance on 1-10-13.		
K 045 SS=D		K 045			

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345	
(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 045	<p>Continued From page 9</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, sixteen (16) residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at four (4) exits.</p> <p>The findings include:</p> <p>Observation, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed the exterior exits at the back office exit and the garden exit did not have any light for illumination of the outside of the exit. Further observation revealed the kitchen area exits had only a single light for illumination of the outside of the exit.</p> <p>Interview, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path.</p>	K 045	<p>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>-No residents were affected by the deficient practice. Regulated illumination for exteriors to the back office door, the garden door and the kitchen doors were installed on 1-8-13. See Photos #3, #4, &amp; #5</p> <p>How will this facility identify other residents having the potential to be affected by the same deficient practices?</p> <p>-All residents had the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>-Exterior illumination added to the Environmental Safety Weekly Report.</p> <p>How will this facility plan to monitor its performance to ensure that solutions are maintained?</p>	1-11-13

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
(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 045	Continued From page 10  Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	-Environmental Safety Weekly Reports shall be monitored by the Safety team. The Safety Team shall monitor the Environmental Safety Supervisor for six months and resume yearly review after no further deficient practices are identified. The Safety Team shall report to the Quality Assurance Team Quarterly. On 1-10-13 a safety round was completed by the Administrator, Director of Nurses, Quality Assurance Coordinator and the Environmental Safety Supervisor with no deficient practice observed. The facility is alleging compliance on 1-10-13.		
K 047 SS=F	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  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 four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure three (3) exit paths were clearly marked.  The findings include:  Observation, on 12/12/12 between 1:10 PM and 3:00 PM with the Maintenance Supervisor, revealed the egress paths in the business corridor were not clearly marked. Further observation showed once the fire doors closed	K 047	047 What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  -No residents were affected by the deficient practice. The egress to the business corridor has been clearly marked, "This Is Not An Exit" on 1-3-2013. Exit signs were added at the side exits at the Nurses' station on 1-3-2013. See attached photos #6 & #7  How will this facility identify other residents having the potential to be affected by the same deficient practices?	1-11-13	

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345	
(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 047	Continued From page 11 the side exits at the nurses' station did not have exit signs.  Interview, on 12/12/12 between 1:10 PM and 3:00 PM with the Maintenance Supervisor, revealed he was unaware the facility did not have proper exit signage.  Reference: NFPA 101 (2000 edition)  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.  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 record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random	K 047	-All residents had the potential to be affected by the deficient practice  What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  -Exit Signs added to Environmental Safety Rounds.  How will this facility plan to monitor its performance to ensure that solutions are maintained?  -Safety Rounds are reviewed weekly as part of the Safety Team meeting. The Safety Team reports quarterly to the Quality Assurance Team. The Safety Team shall monitor the Exit Signs for one year to ensure that compliance is met. On 1-10-13 a safety round was completed by the Administrator, Director of Nurses, Quality Assurance Coordinator and the Environmental Safety Supervisor with no deficient practice observed. The facility is alleging compliance on 1-10-13.  050 What Corrective Action will be accomplished for those residents to have been affected by the deficient practice?	
K 050 SS=F		K 050		1-8-13

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 12 times, 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-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times.  The findings include:  Fire Drill review, on 12/12/12 at 9:43 AM with the Maintenance Supervisor, revealed the fire drills were not being conducted at random times on all shifts. Fire drills on second shift were conducted routinely between 7:30 PM and 8:30 PM, and third shift routinely between 11:00 PM and 11:30 PM. Further observation revealed third shift fire drills were always performed on the same day as second shift.  Interview, on 12/12/12 at 9:43 AM with the Maintenance Supervisor, revealed he was unaware the fire drills were not being conducted as required. The Maintenance Supervisor was unaware of the time separation on each shift to consider the times unexpected.  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	-No residents were affected by the deficient practice. The Fire drills shall be held at unexpected times under varying conditions at least quarterly on each shift.  How will this facility identify other residents having the potential to be affected by the same deficient practices?  -All residents had the potential to be affected by the deficient practice  What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  -Fire Drills added to Safety Team weekly report.  How will this facility plan to monitor its performance to ensure that solutions are maintained?  -The Safety Team shall monitor the Fire Drill offerings monthly for six months and then resume to yearly checks to ensure that there is no deficient practice. The facility is alleging compliance on 1-7-13.	
K 056 SS=F	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		

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
(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 056	<p>Continued From page 13</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 four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures and installed in all areas of the facility.</p> <p>The findings include:</p> <p>Observations, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed the sprinkler heads located in the isolation supplies room, business office restroom, medical records office, and storage room E hall were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprnklr heads. Resident rooms 304, 302 and throughout e hall also had blocked sprinkler heads due to</p>	K 056	<p>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>-No residents were affected by the deficient practice. The cited ceiling fans located in the Social Service office and the offices in the Julian Sparks corridor were removed on 12-27-12. The facility contracted with Premier Fire Protection, Inc to meet the standard set forth by the NFPA 101 Life Safety Code for the sprinkler system modification on 12-19-12.</p> <p>How will this facility identify other residents having the potential to be affected by the same deficient practices?</p> <p>-All residents had the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>-Sprinkler Heads added to the weekly Environmental Safety Rounds report.</p> <p>How will this facility plan to monitor Its performance to ensure that the Solutions are maintained?</p>	12-20-12	

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
(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 056	<p>Continued From page 14</p> <p>light fixtures. Further observation revealed the sprinklers were blocked by ceiling fans in the social services office and the offices on the Julian Sparks corridor.</p> <p>Interview, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head.</p> <p>Observation, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed the closet in the conference room and the back area of the central bath on c hall were not sprinkler protected.</p> <p>Interview, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed he was not aware that the areas listed did not have proper sprinkler protection.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.6.2.2 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> <p style="text-align: center;">Maximum Allowable Distance Distance from Sprinklers to      of Deflector</p>	K 056	-The Safety Team shall monitor the weekly Environmental Safety rounds completed by the Environmental Safety Supervisor for six months. The Safety Team shall report to the Quality Assurance Team quarterly. After six months observation of the Environmental Safety Supervisor with no deficient practice noted, the monitoring shall return to quarterly reporting. The facility is alleging a projected compliance date of 12-19-12.		

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012																						
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345																							
(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 056	<p>Continued From page 15 above Bottom of Side of Obstruction (A) Obstruction (In.)</p> <table border="0"> <tr><td>(B)</td><td>0</td></tr> <tr><td>Less than 1 ft</td><td>21/2</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>31/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>51/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>71/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>91/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>12</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>14</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>161/2</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>18</td></tr> <tr><td>5 ft and greater</td><td></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).</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.6.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed</p>	(B)	0	Less than 1 ft	21/2	1 ft to less than 1 ft 6 in.	31/2	1 ft 6 in. to less than 2 ft	51/2	2 ft to less than 2 ft 6 in.	71/2	2 ft 6 in. to less than 3 ft	91/2	3 ft to less than 3 ft 6 in.	12	3 ft 6 in. to less than 4 ft	14	4 ft to less than 4 ft 6 in.	161/2	4 ft 6 in. to less than 5 ft	18	5 ft and greater		K 056		
(B)	0																									
Less than 1 ft	21/2																									
1 ft to less than 1 ft 6 in.	31/2																									
1 ft 6 in. to less than 2 ft	51/2																									
2 ft to less than 2 ft 6 in.	71/2																									
2 ft 6 in. to less than 3 ft	91/2																									
3 ft to less than 3 ft 6 in.	12																									
3 ft 6 in. to less than 4 ft	14																									
4 ft to less than 4 ft 6 in.	161/2																									
4 ft 6 in. to less than 5 ft	18																									
5 ft and greater																										

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
(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 056	Continued From page 16 maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056			
K 062 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  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, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the gauges on the sprinkler riser had been replaced or recalibrated within the past five (5) years.  The findings include:  Observation and record review, on 12/12/12 at 10:32 AM with the Maintenance Supervisor, revealed the facility failed to provide documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last 5 years. The gauges were dated 2005 as the last time they were replaced.  Interview, on 12/12/12 at 10:32 AM with the	K 062	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  -No residents were affected by the deficient practice. The gauges on the sprinkler riser were replaced on 12-21-12.  How will this facility identify other residents having the potential to be affected by the same deficient practices?  -All residents had the potential to be affected by the deficient practice.  What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  -Sprinkler System added to yearly contracts check.  How will this facility plan to monitor its performance to ensure that solutions are maintained?	1-11-13	

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345		
(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 062	Continued From page 17 Maintenance Supervisor, revealed he was not aware the gauges on the sprinkler riser had to be calibrated or replaced once every 5 years.  Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3	K 062	-The Administrator or designee shall monitor the sprinkler system and sprinkler system testing records for one year to ensure that compliance is met. The Administrator or designee shall report quarterly to the Quality Assurance Team. On 1-10-13 a safety round was completed by the Administrator, Director of Nurses, Quality Assurance Coordinator and the Environmental Safety Supervisor with no deficient practice observed. This facility is alleging compliance on 1-10-13.		

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345	
(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 062	Continued From page 18 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 60 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		
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 98  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure manual activation devices, for the kitchen hood system, was readily available. The deficiency had the potential to affect one (1) of four (4) smoke compartments, ten (10) residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the manual pull for the hood suppression was located in the egress path and proper signage for the fire extinguisher in the kitchen.	K 069	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  -No residents were affected by the deficient practice. This facility moved the manual activation devices for the kitchen hood system to a readily available location in an egress path on 12-28-12. Signage stating that the hood suppression system must be used before the class K fire extinguisher was added on 12-28-12. See Photo #8	12-29-12

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42346	
(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 069	Continued From page 19  The findings include:  Observation, on 12/12/12 at 2:30 PM with the Maintenance Supervisor, revealed the manual activation device for the hood suppression system was not located in an egress path. This was confirmed with the Maintenance Director.  Interview, on 12/12/12 at 2:30 PM with the Maintenance Supervisor, revealed he was not aware of the manual activation device being required in an egress path.  Observation, on 12/12/12 at 2:52 PM with the Maintenance Supervisor, revealed there was no signage stating that the hood suppression system must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.  Interview, on 12/12/12 at 2:52 PM with the Maintenance Supervisor, revealed he was unaware of the signage requirement.  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 other. Exception No. 1: The manual means of system	K 069	How will this facility identify other residents having the potential to be affected by the same deficient practices?  -All residents had the potential to be affected by the deficient practice.  What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  -Manual fire fighting equipment added to the Environmental Safety Rounds.  How will this facility plan to monitor its performance to ensure that solutions are maintained?  -The Safety Team shall monitor the Fire Drill offerings monthly for six months and then resume to yearly checks to ensure that there is no deficient practice. The facility is alleging compliance on 12-28-12.	

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345	
(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 069	Continued From page 20 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.  Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher	K 069		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, no residents, staff and visitors. The facility is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure two (2) space heaters in employee areas did not exceed 212 degrees Fahrenheit.  The findings include:  Observation, on 12/12/12 between 1:10 PM and	K 070	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  -No residents were affected by the deficient practice. The portable space heaters were removed from the office areas sited on 12-12-12. An In-Service was held regarding the prohibited use of portable space heaters in this facility on 1-8-13 by the Safety Team Coordinator.  How will this facility identify other residents having the potential to be affected by the same deficient practices?  -All residents had the potential to be affected by the same deficient practice.  What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	1-10-13

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42346	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 070	Continued From page 21 3:00 PM with the Maintenance Supervisor, revealed a portable space heater located in the social services office and Anne ' s office.  Interview, on 12/12/12 between 1:10 PM and 3:00 PM with the Maintenance Supervisor, revealed he was not aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas.  Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD	K 070	-Office section added to the Weekly Environmental Safety Rounds.  How will this facility plan to monitor its performance to ensure that solutions are maintained?  -The Administrator or designee shall monitor the Weekly Environmental Safety Rounds for 6 months and report Quarterly to the Quality Assurance Team for one year to ensure that there is no deficient practice. The facility is alleging compliance on 1-9-13.	
K 074 SS=F	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.  Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13  Newly introduced mattresses meet the criteria	K 074	What Corrective Action will be accomplished for those residents to have been affected by the deficient practice?  -No residents were affected by the deficient practice. On 12-21-12 the privacy curtains located in the shower rooms on c-hall and e-hall were corrected by adding extensions to the privacy curtains that meet the regulation standard. The curtain is hung 18" below the sprinkler head so that the top of the curtain does not obstruct the spray pattern of the sprinkler heads. See Photo #9 & #10	12-22-12

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345	
(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 074	Continued From page 22 specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4, 19.7.6.3  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were 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-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure shower curtains in two (2) baths were at proper heights for sprinkler coverage.  The findings include:  Observation, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed the privacy curtains within the shower rooms located on c hall and e hall, were of a solid fabric with no mesh for sprinkler coverage.  Interview, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed he was unaware the shower curtains must contain 18" of mesh or be hung 18" below the sprinkler head so that the top of the curtain does not obstruct the spray pattern of the sprinkler heads.  NFPA 13	K 074	How will this facility identify other residents having the potential to be affected by the deficient practices?  -All residents had the potential to be affected by the deficient practice.  What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?  -Privacy Curtains/Spinkler heads added to the weekly Environmental Safety Rounds.  How will this facility plan to monitor its performance to ensure that the solutions are maintained?  -The Safety Team shall monitor the weekly Environmental Safety rounds completed by the Environmental Safety Supervisor and report to the Quality Assurance Team Quarterly for six months and resume reporting quarterly to the Quality Assurance Team to ensure that there is no deficient practice. On 1-10-13 a safety round was completed by the Administrator, Director of Nurses, Quality Assurance Coordinator and Environmental Safety Supervisor with no deficient practice observed. The facility is alleging compliance on 12-21-12.	

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345	
(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 074	Continued From page 23 Cubicle curtains; Reference to: NFPA 13 Standard for the Installation of Sprinkler Systems 1998 Edition 19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using a 1/2-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074		
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, ten (10) residents, staff and visitors. The facility	K 147	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?  -No residents were affected by the deficient practice. The regulated standard space provided for the electrical panel in the office supply room was cleared on 12-28-12. The regulated standard space provided for the electrical panel in the kitchen pantry was cleared on 12-28-12 See Photos #11 & #12	12-29-12

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 621 GREENE DR. GREENVILLE, KY 42345	

(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 24</p> <p>is certified for Sixty-Two (62) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure two (2) electrical panels maintained three (3) feet of clearance around them.</p> <p>The findings include:</p> <p>Observations, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed the electrical panel in the office supply room and the dry storage for the kitchen had storage within 3 feet of the electrical panels.</p> <p>Interview, on 12/12/12 between 11:00 AM and 2:45 PM with the Maintenance Supervisor, revealed he was unaware there could not be storage within 3 feet of electrical panels.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>110-26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or</p>	K 147	<p>How will this facility identify other residents having the potential to be affected by the same deficient practices?</p> <p>-All residents had the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>-Electrical panels added to the weekly Environmental Safety Rounds.</p> <p>How will this facility plan to monitor its performance to ensure that solutions are maintained?</p> <p>-The Safety team shall monitor the weekly Environmental Safety Rounds report completed by the Environmental Safety Supervisor for six months. The Safety Team shall report to the Quality Assurance team quarterly. After six months monitoring of no deficient practices observed the Environmental Safety Supervisor shall report quarterly to the Safety Team as part of the Quality Assurance program. This facility is alleging compliance on 12-28-12.</p>	

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/12/2012																				
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345																					
(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 25 permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td colspan="2">1 m (3½ ft)</td> </tr> <tr> <td>1.2 m (4 ft)</td> <td colspan="3"></td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)		1.2 m (4 ft)				K 147		
Nominal Voltage to Ground	Minimum Clear Distance																							
Condition 1	Condition 2	Condition 3																						
0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)																					
151-600	900 mm (3 ft)	1 m (3½ ft)																						
1.2 m (4 ft)																								

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
(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 26</p> <p>than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.</p> <p>(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.</p> <p>(c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation.</p> <p>(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.</p> <p>(3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment.</p> <p>(B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for</p>	K 147			

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
(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 27</p> <p>inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded.</p> <p>(C) Entrance to Working Space.</p> <p>(1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment.</p> <p>(2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met.</p> <p>(a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted.</p> <p>(b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition.</p> <p>(D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work</p>	K 147			

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

PRINTED: 01/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2012
NAME OF PROVIDER OR SUPPLIER  BELLE MEADE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	Continued From page 28 space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.	K 147			