

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

PRINTED: 10/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/05/2015
NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 10/05/15, as alleged.	{F 000}		

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

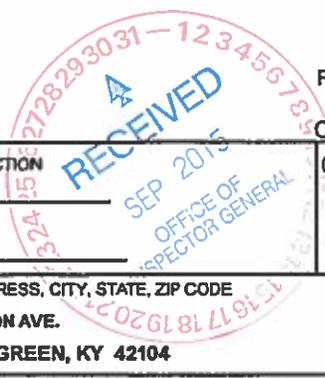
TITLE

(X6) DATE

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

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

PRINTED: 09/23/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2015
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the residents' environment remained free from accident hazards as possible for one (1) of five (5) sampled residents (Resident #1).</p> <p>On 09/02/15 at 4:41 PM, Resident #1 was left unsupervised in the hallway, and was able to open an unsecured chemical door on a housekeeping cleaning cart and potentially drink out of an opened bottle of diluted bleach solution.</p> <p>The findings include: Review of the facility's policy titled, "Healthcare Services Group, Housekeeping In-Service", dated 01/01/00, revealed a locking box was required if chemicals were stored on the cart and this is</p>	F 323	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (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.</p>	10/5/15 JG

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Glenn Shepherd* TITLE: Administrator DATE: 9-28-15

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: 09/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2015
NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1661 NEWTON AVE. BOWLING GREEN, KY 42104	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 1</p> <p>especially important in resident areas. The cart should never be left unattended in any work area. Report repair requirement immediately and never leave chemicals unattended on carts. A 1:10 bleach solution must be used for decontamination and bottles of the bleach solution must be made up daily.</p> <p>Review of a Material Safety Data Sheet (MSDS) for Clorox Bleach, dated 12/2009, revealed health hazard data listed as mild to moderate skin irritation, harmful if swallowed, and may cause nausea and vomiting if swallowed. Under normal consumer use conditions, the likelihood of any adverse health effects is low.</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Hypertension, Senile Dementia, Dysphagia, and Alzheimer's Disease. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 05/08/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of three (3), indicating the resident was not interviewable.</p> <p>Review of the facility's Incident Investigation, dated 09/02/15 at 4:41 PM, revealed Resident #1 had been assisted out of bed and into his/her wheelchair, and Certified Nurse Aide (CNA) #1 rolled the resident into the hallway. Further review of the investigation revealed CNA #1 had taken the housekeeping cart to the hallway outside the resident's room to clean a spill from the floor and the CNA did not check the chemical door on the housekeeping cart prior to removing it from the storage closet and parking it unsupervised outside the resident's room.</p>	F 323	<p><u>F323</u></p> <p><u>Residents affected</u></p> <ol style="list-style-type: none"> Resident #1 had bottle removed immediately from him. Resident #1 was assessed and given oral care. Poison control was contacted. Fluids/food given to resident. Resident was monitored for nausea, vomiting or other GI upset. Resident was placed on 15 minute checks with MD and family notified. Cart was taken and locked up in Housekeeping closet. <p><u>Residents Potentially Affected</u></p> <ol style="list-style-type: none"> Residents who are mobile have the potential to be affected by the alleged deficient practice. <p><u>Measures/Systematic Changes</u></p> <ol style="list-style-type: none"> Education given to all staff on ensuring all chemicals are locked and out of reach of residents by Administrator on October 1st. Staff will not be allowed to work after October 5, 2015 until they have completed Education by the Administrator. 	10/5/15 JA

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

PRINTED: 09/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/10/2015
NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1661 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 2 Interview with CNA #1, on 09/09/15 4:30 PM, revealed when she came on shift and completed room checks she noticed Resident #1's room needed some attention. CNA #1 stated she provided personal care for Resident #1, then placed him/her in the wheelchair and placed him/her in the hallway. CNA #1 revealed she placed the housekeeping cart outside the resident's room to use the mop. CNA #1 stated she did not check the chemical door on the cart to see if it was locked because she was not going to use anything from the cart except for the mop and mop bucket. CNA #1 said when she saw Resident #1 outside the cart with an opened bottle of bleach solution in his/her hand, she immediately removed the bottle and did not see a lid for the bottle. CNA #1 stated the bottle was labeled bleach but she was not able to find the lid to the spray bottle. Interview with Housekeeping Supervisor, on 09/09/15 at 9:10 AM and on 09/10/15 at 12:20 PM, revealed it was the facility policy that at the end of each shift all carts should be locked and to never store chemicals on top of the cart. He stated the carts were locked and stored in the cleaning closet at the end of each shift. He further revealed the door to the cleaning room is a combination lock, but the keys to the cleaning carts are stored in his office and can only be opened with a key. He stated at the time of the incident, if nursing staff needed a mop and mop water they would have to take the entire cart to the area they were using it in. He further stated this could have been a horrible situation and he expected the carts to be locked at the end of each shift and during daily use. He further revealed he did not realize the locks were	F 323	<ol style="list-style-type: none"> Education to all housekeeping staff to keep their carts locked at all times, do not store chemicals on top of the cart and ensure carts are locked when stored at the end of the day by Administrator on October 1st or unable to work after October 5, 2015 until completing the education by the Administrator. New locks installed on all housekeeping carts on 9/11/15 by Healthcare Services Group (RDO). Beginning 9/13/15 Healthcare Services Group is providing a wet mop for use by the facility employees for after hours use. <p><u>Monitoring Changes</u></p> <ol style="list-style-type: none"> Housekeeping carts to be audited by Housekeeping Supervisor or Administrator daily x (4) four weeks and monthly times (2) two months and quarterly times (1) one quarter to ensure that carts are being locked and no chemicals are stored on top of the carts. <p>The results of the audits will be reviewed at the Quality Assurance Committee</p>	10/5/15 AS	

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

PRINTED: 09/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/10/2015
NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 3 defective and had not been completing any type of checks on the locks prior to this incident. He stated after this incident we realized the locks were defective and replaced both locks on each housekeeping cart. Interview with Director of Nursing, on 09/09/15 at 8:15 AM, revealed housekeeping was responsible for the housekeeping cart and the incident happened after housekeeping had left for the day. She stated the cart was pulled to the doorway of Resident #1's room and the mop was used to clean the floor and CNA #1 did not check the door to see if it was locked because she did not use any chemicals from the door. She stated she expected the cart to be locked prior to storing it in the cleaning closet.	F 323	(Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, Pharmacy, Social Services, Medical Director, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.	10/5/15	