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

PRINTED: 10/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185435		09/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA VILLAGE	1381 CAMPBELL LANE 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 A standard health survey was initiated on 09/17/13 and concluded on 09/19/13 with a Life Safety Code Survey conducted on 09/18/19. Deficiencies were cited with the highest scope and severity of an "E". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	*"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Magnolia Village Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."*	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for nine (9) rooms. Eight (8) resident room doors had rough and chipped edges with missing wood (rooms 107, 111, 226, 228, 330, 333, 335 and 336) and one (1) resident room with a hole in the wall by the floor board (room 340). The findings include: Review of the facility's policy titled Preventative Maintenance, not dated, revealed touch up painting and facility specific items are to be preformed monthly. Observations conducted during the environmental	F 253	**F253** Maintenance Director repaired the hole in room 340 on 9/23/13. The doors in rooms 107, 111, 226, 228, 330, 333, 335 and 336 were repaired by the Maintenance Director on 10/4/13. An audit was conducted on 10/4/13 of all of the resident's rooms and doors to assess for sanitary, orderly and comfortable environment by the Administrator. Any findings will be repaired by 10/11/13. Staff re-education provided by the Administrator and AP Payroll Coordinator, Regarding maintaining the resident care environment and notification of the Maintenance Director of environmental repair needs such as holes in the walls and rough and chipped doors by 10/11/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X [signature] TITLE X Administrator X (X6) DATE 10/9/13

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

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F 253	Continued From page 1 tour, on 09/18/13 at 4:04 PM, revealed entry doors for resident rooms 107, 111, 226, 228, 330, 333, 335 and 336 had edges that were rough and chipped with missing wood. Further observations revealed in resident room 340 a hole in the wall close to the baseboard. Interview, on 09/19/13 at 4:45 PM, with the Maintenance Supervisor revealed the Maintenance Supervisor made a monthly round of each area of the facility and addressed any issues in that area at that time as follows: the first week of the month is Hall One (1), the second week of the month is Hall Two (2), the third week of the month is Hall Three (3) and the fourth week is the general areas of the facility. The interview further revealed this was the third week of the month so the Hall Three would have been observed and worked on, but the Maintenance Supervisor had to be off that week. The Maintenance Supervisor denied being aware of the hole in the wall in room 340, but did reveal the issues with the doors was an ongoing problem due to wheelchairs. Interview, on 09/19/13 at 1:55 PM, with the Administrator revealed the facility was not aware of the hole in room 340; however, the issue with the resident entry doors was on-going due to wheelchairs. The interview further revealed the Maintenance Supervisor made monthly rounds in the facility and addressed any issues that were identified at that time. The interview further revealed if staff noticed a problem it was added to the maintenance book which was monitored daily by the maintenance supervisor.	F 253	The Maintenance Director will conduct facility rounds weekly for four weeks, then monthly to assess for sanitary, orderly and comfortable environment and will report results to the Safety Committee and Performance Improvement Committee monthly for three months then quarterly for one year for further recommendations. Completion Date	10/18/13

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K 000	INITIAL COMMENTS	K 000		

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1990

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type III (111)

SMOKE COMPARTMENTS: Five (5) smoke compartments

FIRE ALARM: Complete fire alarm system with heat and smoke detectors

SPRINKLER SYSTEM: Complete automatic dry sprinkler system.

GENERATOR: Type II generator. Fuel source is Natural Gas.

A standard Life Safety Code survey was conducted on 09/18/13. Magnolia Village was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of fifty eight (58) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X [signature] TITLE X Administrator X (X6) DATE 10/9/13

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K 000	Continued From page 1	K 000		
	Deficiencies were cited with the highest deficiency identified at E level.			
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	**K029** On 10/09/13 closing arms were added to the doors of the Business Office, Medical Records, Administrator, Director of Nursing Office, Social Services Office, and the MDS Office by Maintenance Director. An audit was conducted on 10/3/13 by the Maintenance Director and revealed no further rooms requiring self-closing doors protecting hazardous areas. Maintenance Director was re-educated on the requirements for protection from hazards on 10/7/13 by the Administrator. Maintenance Director will conduct audits weekly for four weeks and three audits per month for an additional two months to monitor the door closures are in place and properly working and self-closing. Maintenance Director will report results to the Safety Committee and Performance Improvement Committee monthly for three months and then quarterly for one year for further recommendations. Completion Date	10/18/13
	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 five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The facility failed to maintain self-closing doors protecting hazardous areas.			
	The findings include:			
	Observation, on 09/18/13 at 3:24 PM, with the Maintenance Director revealed the doors to the			

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K 029	Continued From page 2 Business Office, Medical Records Office, Administrators Office, Director of Nursing Office, Social Services Office, and the MDS Office had door closers installed due to the amount of hazardous combustible storage kept in these rooms. However, the closing arm had been removed from these doors making them no longer self-closing. Interview, on 09/18/13 at 3:24 PM, with the Maintenance Director revealed he was not aware of the requirements for protection from hazards. 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. 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:	K 029		

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K 029	Continued From page 3 (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency	K 038	**KO38** On 9/19/13 Maintenance Director for Hopkins Center added a background immediately creating a contrasting background making the signage easily visible. Administrator completed a facility door audit on 9/19/13 and all doors identified were immediately fixed to be in compliance with NFPA 101. The Maintenance Director was re-educated by the Administrator on 10/4/13 regarding proper signage. The Administrator will inspect the facility delayed egress doors to validate each contains a contrasting background on the signage so that it's easily visible. Audits will be conducted at least monthly for 3 months then quarterly for one year. The Administrator will report findings to the Performance Improvement Committee for further recommendations. Completion Date	10/18/13

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K 038	Continued From page 4 had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The facility failed to maintain signage for doors equipped with delayed egress locks. The findings include: Observation, on 09/18/13 between 1:30 PM and 3:30 PM, with the Maintenance Director revealed four (4) of the facilities eight (8) glass exit doors were equipped with delayed egress locks and signage. However, the signage was not clearly recognizable due to the lettering was installed on a glass door without a contrasting background. Interview, on 09/18/13 between 1:30 PM and 3:30 PM, with the Maintenance Director revealed he was not aware the delayed egress signage was required to have a contrasting background. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in	K 038		

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K 038	Continued From page 5 accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.	K 038		

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K 038	Continued From page 6 (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038	**K056** The Facility Maintenance Director relocated the two light fixtures in the Activity Room and the two light fixtures in the kitchen on 10/08/13. The Maintenance Director conducted a facility wide audit to identify light fixtures installed within twelve inches of a sprinkler head on 10/1/13. All identified areas will have the light fixture relocated by 10/11/13. The Maintenance Director was re-educated by the Administrator on 10/7/13 regarding the maximum allowable distance of sprinkler heads and an obstruction per NFPA standards. The Maintenance Director will conduct monthly audits of sprinkler heads for three months then quarterly for one year to ensure they meet standards of the NFPA standards. The Maintenance Director will report findings to the Performance Improvement Committee for further recommendations.	
K 056 SS=D	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 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	K 056		
			Completion Date	10/18/13

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K 056	Continued From page 7	K 056		

This STANDARD is not met as evidenced by:
Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The facility failed to ensure the facility had complete sprinkler coverage.

The findings include:

Observation, on 09/18/13 at 1:49 PM, with the Maintenance Director revealed light fixtures installed within twelve (12) inches of a sprinkler head, extending below the deflector of the sprinkler head and obstructing the sprinkler from developing a full pattern. Two (2) sprinkler heads in the Activities Room, and two (2) sprinkler heads in the Kitchen were affected.

Interview, on 09/18/13 at 1:49 PM, Maintenance Director revealed he was not aware the sprinkler heads were blocked by the light fixtures.

Reference: NFPA 13 (1999 Edition) 5-13 8.1

Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. 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

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K 056	Continued From page 8	K 056		

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 maximum protection area per sprinkler
(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.

Reference: NFPA 13 (1999 ed.)
5-5.5.2.2 Sprinklers shall be positioned in accordance with
the minimum distances and special exceptions of Sections 5-6
through 5-11 so that they are located sufficiently away from
obstructions such as truss webs and chords, pipes, columns,
and fixtures.
Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B	Maximum Allowable Distance of Deflector Obstruction (in.)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	21/2
1 ft 6 in. to less than 2 ft	31/2

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K 056	Continued From page 9	K 056		

2 ft to less than 2 ft 6 in. 51/2
2 ft 6 in. to less than 3 ft 71/2
3 ft to less than 3 ft 6 in. 91/2
3 ft 6 in. to less than 4 ft 12
4 ft to less than 4 ft 6 in. 14
4 ft 6 in. to less than 5 ft 161/2
5 ft and greater 18

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).
Reference: NFPA 13 (1999 ed.)
5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.

Reference: NFPA 13 (1999 Edition)

7-2.3.2.4 Where listed quick-response sprinklers are used
throughout a system or portion of a system having the same
hydraulic design basis, the system area of operation shall be
permitted to be reduced without revising the density as indicated
in Figure 7-2.3.2.4 when all of the following conditions
are satisfied:
(1) Wet pipe system
(2) Light hazard or ordinary hazard occupancy
(3) 20-ft (6.1-m) maximum ceiling height
The number of sprinklers in the design area shall never be
less than five. Where quick-response sprinklers are used on a
sloped ceiling, the maximum ceiling height shall be used for
determining the percent reduction in design area. Where

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185435		09/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA VILLAGE	1381 CAMPBELL LANE BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 10 quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 21/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 056		
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler,	K 068		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA VILLAGE	1381 CAMPBELL LANE BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 068	Continued From page 11 incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, fuel fired HVAC, and water heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty eight (58) on the day of the survey. The findings include: Observation, on 09/18/13 at 2:54 PM, with the Maintenance Director revealed the fresh air vents serving the gas fired water heater were located in the Dining Room Storage Room. The vent was not continuous to the outside but instead open to the attic space. Interview, on 09/18/13 at 2:54 PM with the Maintenance Director revealed he was not aware the vent had been missed when he had others in the building vented to the outside. Reference: NFPA 101 Life Safety Code (2000 edition) Section 19.5 Building Services 19.5.2.2	K 068	**K068** Bowling Green Refrigeration submitted approved bid to the Administrator to repair the vent according to NFPA standards on by 10/18/13. The Maintenance Director conducted an audit on 9/23/13 and no other vents were out of compliance according to NFPA standards. The Maintenance Director was re-educated by Administrator on 10/4/13 on the standard according to the NFPA related to vents in the mechanical rooms with gas fired equipment. Maintenance Director will review monthly for three months then quarterly for one year and report findings to Performance Improvement Committee for further recommendations. Completion Date:	~~10/18/13~~ 10-19-13 per Amy Phelps By PB 10-14-13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING** B. WING _____	(X3) DATE SURVEY COMPLETED
	185435		**09/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA VILLAGE	**1381 CAMPBELL LANE** **BOWLING GREEN, KY 42104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 068	Continued From page 12 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 068		

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