

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

PRINTED: 04/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2015
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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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<p>F 000</p> <p>F 281 SS=D</p>	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted on 03/24/15 through 03/26/15 with deficiencies cited at a Scope and Severity of a "D".</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policies, and review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS)#14, it was determined the facility failed to ensure services provided by the facility meet professional standards of quality for one (1) of twenty-four (24) sampled residents (Resident #11). The physician ordered Resident #11 to have a dressing change to an abdominal wound two (2) times daily. Observation on 03/25/15 revealed Registered Nurse (RN) #1 failed to follow the Physicians orders.</p> <p>The findings include:</p> <p>Review of the Kentucky Board of Nursing AOS #14 Patent Care Orders, last revised 10/2010, revealed licensed staff (registered nurses and licensed practical nurses) should administer medication and treatment as prescribed by the physician or advanced practice registered nurse.</p> <p>Review of the facility's policy, "Wound Care Protocol (Version Date: 1/10)" revealed "Wet to Dry NSS Dressings (Mechanical) number one (1)</p>	<p>F 000</p> <p>F 281</p>	<p>Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this</p> <p>Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.</p> 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 4/30/15

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.

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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSDALE RD. 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 281	<p>Continued From page 1</p> <p>"Cleanse wound thoroughly with normal saline or with appropriate wound cleanser".</p> <p>Review of the facility's undated policy, "Receipt of Physician's Orders (Pages twenty-one and twenty-two) revealed the nurse was to enter the order on the resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR) in compliance with State and Federal regulations and such orders must be countersigned by the prescriber within two (2) days.</p> <p>Record review revealed the facility admitted Resident #11 on 03/11/15 with diagnoses which included Muscular Wasting and Disuse Atrophy NEC, Septic Shock, Open Wound Abdominal Wall Anterior Complicated, and Cognitive Communication Deficit. Review of the Admission Minimum Data Set (MDS) assessment, dated 03/18/15, revealed the facility had assessed Resident #11's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of 09 indicating the resident was interviewable and as requiring extensive assistance with all activities of daily living.</p> <p>Review of the Physician's Orders, dated 03/12/15, revealed a treatment order to clean Resident #11's abdominal surgical wound with normal saline and apply a wet to dry dressing twice daily.</p> <p>Review of the March 2015 TAR revealed "May follow facility wound care protocol" and "Wet to dry to abdomen wound twice daily" and the nurses had initiated treatment as being completed twice daily beginning on 03/12/15 through 03/26/15. The TAR did not include the part of the</p>	F 281	<p>Tag F-281</p> <p>Resident Number 11 is no longer in the facility.</p> <p>A building wide review was conducted of residents' requiring wound care on 3-26-15 to ensure that MD orders and TARs were in congruence. No issues were identified.</p> <p>The Staff Development Coordinator will re-in-service licensed nursing staff that when performing a wound treatment for first time, they must check TAR to MD Order for consistency in transcription to ensure treatment is performed per MD order. This re-in-servicing was initiated on April 16, 2015 with expected completion date of April 20, 2015. Any nursing staff not educated by 4/20/15, will be in-serviced prior to their next shift. To assist with compliance, wound care will be randomly audited (by Nursing Unit Coordinator/DON/ADON/Staff Development Coordinator) on each hallway for compliance per facility protocol weekly for one month, then bi-monthly for one month, then monthly for</p>		

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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104		
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F 281	Continued From page 2 physician's order that stated "to clean wound with normal saline". Observation, on 03/25/15 at 9:00 AM of a dressing change, revealed RN #1 removed a dressing from Resident #11's abdomen and failed to cleanse the abdominal wound with normal saline prior to applying a new dressing as per the Physician's Order. Interview with RN #1, on 03/26/15 at 7:30 AM, revealed she had not been cleansing the resident's wound with normal saline as per the Physician's Order. RN #1 stated she had only been doing a wet to dry dressing. She revealed on 03/12/15 a new nurse transcribed the order on to the resident's TAR and RN #1 had failed to identify the cleanse with normal saline part of the order was not transcribed on to the TAR. Interview with the Director of Nursing (DON), on 03/26/15 at 8:10 AM, revealed she expected nurses to follow Physicians orders when doing treatments as per the facility's policy as that was their standard of practice. Orders were to be transcribed from the written order to the residents' MAR or TAR and it was the responsibility of RN #1 to have identified the order had not been accurately transcribed on to the TAR. Interview with the Administrator, on 03/26/15 at 9:30 AM, revealed he expected the Physician's Order to be followed.	F 281	three months starting April 17, 2015. Upon identification of any potential concerns, the Nursing Unit Coordinator/DON/ADON/ Staff Development Coordinator will take follow up action as necessary. The results of wound care monitoring will be forwarded to the Executive QA Committee monthly which includes Administrator, Medical Director, Director of Nursing, Staff Development Coordinator / QI, Social Service Director, Rehab Director, Activity Director, MDS Nurse, Treatment Nurse, Dietary Director, Medical Records Director, Rehab Unit Director, Long Term Care Unit Director, Housekeeping Director, Admission Director and Maintenance Director for three months for review, identification of trends, for follow-up action as deemed appropriate, and to determine need for and/or frequency of continued monitoring. Staff Development Coordinator will provide yearly re-inservicing of licensed nursing staff regarding checking TAR to MD Order for consistency in transcription to ensure treatment is performed per MD order. Date of completion is 4-20-15		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		4/20/15	

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F 282	<p>Continued From page 3</p> <p>accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility's staff failed to follow a care plan intervention related to prescribed wound care for one (1) of twenty-four (24) sampled residents (Resident #11).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Care Plan", dated 08/2012, revealed the facility should provide an interdisciplinary written care plan based on the physician's orders and the assessment of the resident needs. The development and implementation of the care plan should occur by participating disciplines available in the facility at a team conference under the direction of the Registered Nurse (RN) Coordinator.</p> <p>Review of the facility's policy, "Wound Care Protocol", dated 01/2010, revealed "Wet to Dry NSS Dressings (Mechanical) number one (1) "Cleanse wound thoroughly with normal saline or with appropriate wound cleanser".</p> <p>Review of Resident #11's Comprehensive Care Plan for actual skin impairment related to an abdominal surgical wound, dated 03/16/15, revealed an intervention to provide treatment as ordered or per facility skin care protocol.</p> <p>Review of the Physician's Orders, dated</p>	F 282	<p>F-282</p> <p>Resident number 11 is no longer in the facility.</p> <p>A building wide review was conducted of residents' requiring wound care on 3-26-15 to ensure that MD orders and TARs were in congruence. No issues were identified.</p> <p>The Staff Development Coordinator will re-inservice licensed nursing staff that when performing a wound treatment for first time, they must check TAR to MD Order for consistency in transcription to ensure treatment is performed per MD order. This re-inservicing was initiated on April 16, 2015 with expected completion date of April 20, 2015. Any nursing staff not educated by 4/20/15, will be in-serviced prior to their next shift. To assist with compliance, wound orders will be monitored for consistency (by Nursing Unit Coordinator/Administrative treatment nurse) between TAR and MD order weekly for one month, then bi-monthly for one month, then monthly for three months starting April 17, 2014. Upon identification of any potential concerns, the Nursing Unit Coordinator/Administrative Treatment Nurse/ Staff Development Coordinator will take follow up action as necessary.</p>		

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F 282	Continued From page 4 03/12/15, revealed an order to clean Resident #11's abdominal surgical wound with normal saline and apply a wet to dry dressing twice daily. On 03/25/15 at 9:00 AM, an observation of a dressing change for Resident #11 revealed RN #1 removed a dressing from Resident #11's abdomen and failed to cleanse the abdominal wound with normal saline prior to applying a new dressing as per the Physician's Order and facility protocol. Interview with RN #1, on 03/26/15 at 7:30 AM, revealed she had not been cleansing the resident's wound with normal saline as per the Physician's Order. She had only been doing a wet to dry dressing. Interview with the Director of Nursing (DON), on 03/26/15 at 8:10 A.M., revealed she expected nurses to follow Physicians orders and residents' care plan interventions.	F 282	The results of order monitoring will be forwarded to the Executive QA Committee which includes the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Social Service Director, Activity Director, MDS Nurse, Treatment Nurse, Dietary Director, Medical Records Director, Rehab Unit Director, Long Term Care Unit Director, Housekeeping Director, Admission Director and Maintenance Director monthly for three months for review, identification of trends, for follow-up action as deemed appropriate, and to determine need for and/or frequency of continued monitoring. Staff Development Coordinator will then provide yearly in-servicing of licensed nursing staff regarding checking TAR to MD Order for consistency in transcription to ensure treatment is performed per MD order.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	Date of completion is 4-20-15	4/20/15	

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F 514	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure the clinical record for one (1) of twenty-four (24) residents (Resident #11) was accurately maintained. A Physician's Order obtained on 03/12/15 was not accurately transcribed to the Treatment Administration Record (TAR) resulting in prescribed treatment of a wound not being carried out as ordered. The findings include: Interview with the Director of Nursing (DON), on 03/26/15 at 8:10 AM, revealed there was no facility policy to address the maintenance of the resident clinical record related to accurate documentation. Record review revealed the facility admitted Resident #11 on 03/11/15 with diagnoses to include Muscular Wasting and Disuse Atrophy, Septic Shock, Open Wound Abdominal Wall Anterior Complicated and Cognitive Communication Deficit. Review of a Physician's Order, dated 03/12/15, revealed a signed treatment order to clean abdominal surgical wound with normal saline and apply a wet to dry twice daily; however review of the March 2015 Treatment Administration Record (TAR), revealed the order did not include to clean the abdominal wound with normal saline, it only stated to apply a wet to dry dressing to abdomen	F 514	F-514 Resident number 11 is no longer in facility. A building wide review was conducted of residents' requiring wound care on 3-26-15 to ensure that MD orders and TARs were in congruence. No issues were identified. The Staff Development Coordinator will re-inservice licensed nursing staff that when performing a wound treatment for first time, they must check TAR to MD Order for consistency in transcription to ensure treatment is performed per MD order. This re-inservicing was initiated on April 16, 2015 with expected completion date of April 20, 2015. Any nursing staff not educated by 4/20/15, will be in-serviced		

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F 514	<p>Continued From page 6</p> <p>wound twice daily. Further review revealed the initials of licensed staff indicated the treatment was initiated on 03/12/15 and had been completed twice daily through 03/26/15.</p> <p>Observation on 03/25/15 at 9:00 AM of a dressing change, revealed Registered Nurse (RN) #1 removed a dressing from Resident #11's abdomen and failed to cleanse the abdominal wound with normal saline prior to applying the wet to dry dressing as per the Physician's Order.</p> <p>Interview with RN #1, on 03/26/15 at 7:30 AM, revealed she had not been cleansing the resident's wound with normal saline as per the Physician's Order. She stated she had only been doing a wet to dry dressing. RN #1 revealed on 03/12/15 a new nurse transcribed the order on to the resident's TAR and RN #1 stated she failed to identify the cleanse with normal saline part of the order was not transcribed on to the TAR.</p> <p>Interview with the Director of Nursing, on 03/26/15 at 8:10 AM, revealed orders were to be transcribed from the written order to the residents' Medication Administration Record (MAR) or TAR and it would have been the responsibility of RN #1 on 03/12/15, to have checked and made sure the order was transcribed on to the TAR accurately. She stated Resident #11's record was not accurate because because part of the order reflecting to cleanse the wound with normal saline had not been transcribed to the TAR.</p>	F 514	<p>prior to their next shift. To assist with compliance, wound orders will be monitored for consistency (by Nursing Unit Coordinator/Administrative treatment nurse) between TAR and MD order weekly for one month, then bi-monthly for one month, then monthly for three months starting April 17, 2014. Upon Identification of any potential concerns, the Nursing Unit Coordinator/Administrative Treatment Nurse/ Staff Development Coordinator will take follow up action as necessary.</p> <p>The results of order monitoring will be forwarded to the Executive QA Committee which includes the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Social Service Director, Activity Director, MDS Nurse, Treatment Nurse, Dietary Director, Medical Records Director, Rehab Unit Director, Long Term Care Unit Director, Housekeeping Director, Admission Director and Maintenance Director monthly for three months for review, identification of trends, for follow-up action as deemed appropriate, and to determine need for and/or frequency of continued monitoring. Staff Development Coordinator will then provide yearly in-servicing of licensed nursing staff regarding checking TAR to MD Order for consistency in transcription to ensure treatment is performed per MD order.</p> <p>Date of completion is 4-20-15</p>	4/20/15	

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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1977</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211)</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with two (2) heat and fifty-two (52) smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator, installed in October 2010. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 03/24/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred twenty-eight (128) beds with a census of one-hundred twenty-seven (127) 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>Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this</p> <p>Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE 4/20/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSDALE RD. BOWLING GREEN, KY 42104	
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K 000	Continued From page 1	K 000	K-56	
K 056 SS=D	<p>Deficiencies were cited with the highest deficiency identified at a "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect one (1) of nine (9) smoke compartments, eight (8) residents, staff and visitors. The facility has the capacity for one-hundred twenty-eight (128) beds and at the time of the survey, the census was one-hundred twenty-seven (127). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems.</p> <p>The findings include:</p>	K 056	<p>There are no specific residents identified in the deficiency.</p> <p>A Sprinkler was installed by Stewart Richey Service Group on the 100 Hall middle exit door to cover the requested area on 3/25/15.</p> <p>The Director of Maintenance was in-service on the requirements of K-056 by the administrator on 4/10/15.</p> <p>The Director of Maintenance will complete a Monthly audit to ensure that there is a sprinkler in place on the 100 hall middle exit door along with all other exit doors in the facility</p> <p>Audit findings will be reviewed monthly with the Administrator the DON and the Medical Director during the Executive Quality Improvement meeting which includes the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator / QI, Social Service Director, Rehab Director, Activity Director, MDS Nurse, Treatment Nurse, Dietary Director, Medical Records Director, Rehab Unit Director, Long Term Care Unit Director, Housekeeping Director, Admission Director and Maintenance Director</p> <p>Date of completion is 4/20/15.</p>	4/20/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2015	
NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSVILLE RD. 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	<p>Continued From page 2</p> <p>Observation, on 03/24/15 at 2:35 PM, with the Maintenance Supervisor revealed an exterior porch roof, extending out greater than four (4) feet that was constructed of combustible wood material and did not have sprinkler protection installed below the ceiling. The porch roof was located outside the 100 Hall Side Exit.</p> <p>Interview, on 03/24/15 at 2:36 PM, with the Maintenance Supervisor revealed he was not aware the 100 Hall Side Exit did not have sprinkler protection.</p> <p>The census of one-hundred twenty-seven (127) was verified by the Administrator on 03/24/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/24/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements. 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. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 19.3.5.2*</p>	K 056		

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K 056	<p>Continued From page 3</p> <p>Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria:</p> <p>(1) It shall be in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised.</p> <p>Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>Reference: NFPA 101 (2000 Edition) 9.7 AUTOMATIC SPRINKLERS AND OTHER EXTINGUISHING EQUIPMENT 9.7.1 Automatic Sprinklers. 9.7.1.1*</p> <p>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. Exception No. 1: NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted for use as specifically referenced in Chapters 24 through 33 of this Code. Exception No. 2: NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, shall be permitted for use as provided in Chapters 24, 26, 32, and 33 of this Code.</p>	K 056		

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K 056	Continued From page 4	K 056	K-062 There are no specific residents identified in the deficiency.	
K 062 SS=F	Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain electronic supervision (tamper switches) for a water supply control valve installed on the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect nine (9) of nine (9) smoke compartments, one-hundred twenty-eight (128) residents, staff and visitors. The facility has the capacity for one-hundred twenty-eight (128) beds and at the time of the survey, the census was one-hundred twenty-seven (127). The findings include: Observation, on 03/24/15 at 3:05 PM, with the Maintenance Supervisor revealed the sprinkler system main valve tamper switch failed to sound	K 062	Sprinkler system main tamper switch was replaced on 3/25/15 by Stewart Richey Service Group The Director of Maintenance was in-service on the requirements of K-062 by the administrator on 4/10/15. The Director of Maintenance will complete a weekly audit to ensure that the tamper switch is working and sounds when the wheel is tampered with to ensure alarm does sound. Audit findings will be reviewed monthly with the Administrator the DON and the Medical Director during the Executive Quality Improvement meetings which includes the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Social Service Director, Activity Director, MDS Nurse, Treatment Nurse, Dietary Director, Medical Records Director, Rehab Unit Director, Long Term Care Unit Director, Housekeeping Director, Admission Director and Maintenance Director. Date of completion is 4/20/15.	4/20/15

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K 062	<p>Continued From page 5</p> <p>an alarm to indicate the valve was closed.</p> <p>Interview on 03/24/15 at 3:05 PM, with the Maintenance Supervisor revealed he depended on the sprinkler contractor to keep the tamper switch working as required.</p> <p>The census of one-hundred twenty-seven (127) was verified by the Administrator on 03/24/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/24/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements.</p> <p>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. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>19.3.5.2* Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria:</p> <p>(1) It shall be in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised.</p>	K 062		

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K 062	<p>Continued From page 6</p> <p>Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>Reference: NFPA 101 (2000 Edition) 9.7.2.1*. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.</p>	K 062		