

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



PRINTED: 03/27/2014
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 _____	APR 2014 OFFICE OF INSPECTOR GENERAL	(X3) DATE SURVEY COMPLETED 02/22/2014
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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE, 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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F 000	INITIAL COMMENTS **Amended SOD** A Recertification Survey and an Abbreviated Survey investigating complaint #KY21319 were conducted on 02/19/14 through 02/22/14 to determine the facility's compliance with Federal requirements. #KY21319 was substantiated with related deficiencies. The facility failed to meet the minimum requirements for recertification with the highest Scope and Severity of a "G". On 02/05/14, Resident #14 began showing symptoms of an infection. The physician was made aware and orders were received to infuse three (3) liters of Normal Saline (NS) Intravenously. On 02/06/14, laboratory results were received that indicated Resident #14's sodium and potassium were at critical levels. The physician was notified and orders were received to infuse Dextrose five and a half percent (D 5 1/2%) NS with 10 milliequivalents (meq) of Potassium (K) at 150 cc/hr after current bag of IV fluids was infused. The physician's order did not specify the total amount or duration for infusing the intravenous fluids and the nurse failed to clarify the order to ensure the correct amount of intravenous fluid was infused. Resident #14 received one (1) liter of D 5 1/2% NS. On 02/08/14, the physician was made aware by the family that IV fluids had not been administered since 02/06/14 and the physician directly admitted the resident to the hospital. Resident #14 was diagnosed with Severe Electrolyte Disturbance with a serum sodium of 177 indicating volume depletion.	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, 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. F205 1. Resident # 1 returned to the facility on 02/22/14 and readmitted into their same room as prior to transfer.	3-31-14
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	F 205		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 4-18-14
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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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F 205	<p>Continued From page 1</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Bed Hold Policy - Medicaid Residents, it was determined the facility failed to adhere to their bed-hold policy related to releasing the bed to a new admission resident who was in the hospital for one (1) of the fourteen (14) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Bed Hold - Medicaid Residents", dated 07/01/12, revealed that due to a hospitalization, a bed will be held for either the number of days that the resident indicates or for a maximum of thirty (30) days.</p>	F 205	<p>2. A audit of all transfers in the past thirty (30) days was completed by the Business Office Manager to determine if any resident transferred out of the facility under a bed hold and returned to their held bed. No concerns were identified.</p> <p>3. On 03/10/14 the Administrator re-educated the interdisciplinary team consisting of MDS Nurse, Assistant Director of Nursing, Social Services Director, Dietary Services manager, Medical Records, Business Office Manager, Activities Director, Director of Nursing, Admissions Director, Director of Rehabilitation related to a resident's right when under bed hold to return and retain their current bed unless given permission to move rooms.</p> <p>4. The Administrator will audit all bed holds weekly for twelve (12) weeks to assure that when transferred out of the facility under a bed hold agreement that they returned to their original room. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.</p> <p>F241</p> <p>1. The Director of Nursing observed on</p>	3/31/14
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F 205	<p>Continued From page 2</p> <p>During this time, the resident may return and resume residence in the same room and same bed in this center.</p> <p>Record review revealed the facility admitted Resident #1 on 03/11/13, with diagnoses which included Hypertension, Diabetes type II, Paroxysmal Atrial. Review of the Minimum Data Set (MDS) revealed the facility assessed the resident to have a Brief Interview of Mental Status (BIMS) score of 15, which indicated no impairment in cognition.</p> <p>Review of the Nurse's Notes, dated 02/04/14 at 12:00 PM, revealed Resident #1 was transferred to the hospital Emergency Room for evaluation per physician's order due to a significant change in condition.</p> <p>Review of the Notice of Bed-Hold policy and Rights notice, dated 02/05/14 which was addressed to Resident #1, revealed if an election was made to hold the bed, the resident may return and resume residence in the same room and the same bed in the center.</p> <p>Interview on 02/19/14 at 4:05 PM with Resident #1 revealed, he/she was very upset that his/her room had been given away while he/she was in the hospital. Further review revealed that his/her family had been made aware that the bed was placed on a fourteen (14) day bed hold. Observation revealed the resident was very upset stating that the facility was being paid for the room twice by allowing another resident to stay in his/her room while his/her insurance was paying for it to be held.</p> <p>Interview with Resident #1's daughter, on</p>	F 205	<p>3/10/14 that resident # 1's Foley catheter was in a dignity bag. Resident # 10's sign on the wheel chair was removed as noted by the Director of Nursing on 3/17/14.</p> <p>2. On 3/10/14 the Director of Nursing completed an audit of all resident's with a Foley Catheter and noted that all catheter bags were contained inside a dignity bag. By 3/28/14 the Director of Nursing completed an audit of all resident's rooms and wheel chairs to determine if any signage is undignified any noted to be will be removed.</p> <p>3. All nursing staff will be re-educated on maintaining resident's dignity to include Foley catheter bags being maintained inside a dignity bag and signage that reveals resident information or is undignified. This education will be completed by the Director of Nursing, Assistant Director of Nursing, Unit Manager or RN charge nurse by 3/28/14 with no nursing staff working after 3/28/14 without having received this re-education.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit weekly for twelve (12) weeks all residents with Foley catheters for use of dignity bags and all resident rooms and wheel chairs for inappropriate signage. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing,</p>	

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F 205	Continued From page 3 02/20/14 at 12:05 PM, revealed on 02/05/14 the business office called her to inform her the facility placed the resident's bed on a fourteen (14) day bed hold which she accepted. The daughter was very upset and revealed she was given a copy of the bed hold policy when she visited the facility on 02/06/14; however, when they returned to the facility on 02/06/14, the facility had given the resident's private room to another resident. Interview with the Director of Nursing (DON), on 02/22/14 at 3:10 PM, revealed the facility had received a complex admission while the resident was at the hospital and he/she needed a private room. The DON stated the facility had not made arrangements for the new admission to have a private room and there was no where else to put the resident. The DON stated she made a decision to place the new resident in Resident #1's room and she felt it was a decision she had to make. She stated she talked to the Administrator to discuss what was available. The DON revealed the facility was at fault for not notifying the family of moving Resident #1 out of the private room. The DON revealed if presented with the same situation and same circumstances, she would make the same clinical decision again. She stated "if a resident has a bed hold here, it does not guarantee they will get the same room".	F 205	Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity for two (2) of fourteen (14) sampled residents (Resident #1 and Resident #10). The facility failed to provide a dignity bag for Resident #1's catheter bag which contained yellow fluid and could be seen from the hall outside of the resident's room. Resident #10 had a sign attached to the back of his/her wheelchair that stated "Make sure my alarm is on" for other residents, staff and visitors to see.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Quality of Life-Dignity", (no date), revealed each resident shall be cared for in a manner that promotes and enhances resident quality of life, dignity, respect and individuality. Promotion of resident dignity by helping keep urinary catheter bags covered. In addition, staff should speak respectfully to residents at all times, including addressing the resident by his/her name of choice and not labeling or referring to the resident by his or her room number, diagnosis or care needs.</p> <p>1. Record review revealed the facility admitted Resident #1, on 03/11/13 with diagnoses which included Hypertension, Diabetes, Congestive Heart Failure, Spinal Stenosis and Obesity. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/22/13, revealed the facility assessed Resident #1's cognition to be cognitively intact with a Brief Interview of Mental</p>	F 241		
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F 241	<p>Continued From page 5</p> <p>Status (BIMS) of "15" which indicated the resident was interviewable.</p> <p>Observation, on 01/19/14 at 4:05 PM; and, on 02/20/14 at 12:30 PM, revealed Resident #1 was sitting in a recliner with a urinary catheter bag hanging on his/her walker. The catheter bag contained yellow fluid, it was not covered and was visible to staff, other residents, and visitors from the hallway outside of the resident's room.</p> <p>Interview with Resident #1, on 02/19/14 at 4:20 PM, revealed the staff hung his/her catheter bag on his/her walker. The resident stated it bothered him/her when the catheter bag was not covered when there was "urine" and he/she was wheeled down the hallway.</p> <p>Interview, on 02/20/14 at 1:54 PM with Certified Nursing Assistant (CNA) #5, revealed urinary catheter bags should be covered with dignity bags.</p> <p>Interview, on 02/20/14 at 2:41 PM with Assistant Director of Nursing (ADON), revealed all urinary catheter bags should be covered with a dignity bag.</p> <p>2. Record review revealed the facility admitted Resident #10 on 01/27/14 with diagnoses which included Chronic Obstructive Pulmonary Disease, Lung Cancer, Diabetes Mellitus, Neuropathy, Anxiety, Seizure Disorder and Status Post Liver Transplant.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment, dated 02/03/14, revealed the facility assessed Resident #10 with severe</p>	F 241			

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F 241	Continued From page 6 cognitive impairment. In addition, the facility assessed Resident #10 as needing extensive assistance with activities of daily living and at high risk for falls. Review of the Comprehensive Care Plan, dated 02/15/14, revealed interventions for a chair and bed alarm due to the resident attempted self transfers without assistance. Observations, on 02/21/14 at 10:30 AM and 2:00 PM; and, on 02/22/14 at 9:00 AM, revealed Resident #10 was sitting in his/her wheelchair. The wheelchair had a sign attached to the back of the chair that read "Make sure my alarm is on". Interview with the Administrator, on 02/22/14 at 9:45 AM, revealed he did not think the sign on the back of Resident #10's wheelchair was appropriate. He stated he felt the sign was a dignity issue and was not needed as the resident's care plan should reflect the alarm and staff should be knowledgeable of the care plan.	F 241	F-253 1. The facility has contracted a plumbing company to evaluate and repair the water heating system to maintain water temperatures between 100 and 110 degrees Fahrenheit. The plumbing contractor repaired the water mixing valve 2/19/14. The water temperatures were noted to be between 100 and 110 degrees Fahrenheit and holding properly 2/19/14. 2. The facility has contracted a plumbing company to evaluate and repair the water heating system to maintain water temperatures between 100 and 110 degrees Fahrenheit. The plumbing contractor repaired the water mixing valve 2/19/14. The water temperatures were noted to be between 100 and 110 degrees Fahrenheit and holding properly 2/19/14.		
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, and review of the facility's Maintenance Water Temperature Logs and policy/procedure, it was determined the facility failed to provide the maintenance services necessary to maintain comfortable water temperatures in both shower rooms in the facility and in nine (9) of nine (9) sinks checked in	F 253	3. On 2/19/14 the contracted plumbing company repaired the water heating system mixing valve and water temperatures were noted to be holding properly between 100 – 110 degrees Fahrenheit. During the time of repair showers were not given. The facility policy on water temperatures will be revised to establish zones. Zones will be monitored on a daily basis. This policy will be reviewed by the Medical Director. The Maintenance Director and Department Heads will be educated on the policy by the Administrator by 3/31/14. 4. The Administrator will review water temperature logs weekly for twelve (12) weeks to assure ongoing compliance with		3/31/14

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F 253	<p>Continued From page 7</p> <p>resident's rooms. The facility failed to ensure Maintenance monitored water temperatures to ensure water temperatures were between 100-110 degrees Fahrenheit (F). The water temperatures in hall A shower room was 93 degree F and in "B" shower room was 94 degrees F. In addition, the water temperatures at the sinks in eighteen (18) residents' rooms (rm) were as follows: rm #7 at 98 degrees F, #8 at 96 degrees F, #11 at 64 degrees F, #13 at 92 degrees F, #26 at 99 degrees F, #32 at 99 degrees F, #33 at 95 degrees F, #34 at 94 degrees F, and #35 at 95 degrees F.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy titled, "Water Temperature Log, not dated, revealed the water temperatures must be checked daily at patient room lavatories, at showered faucets, whirlpool tubs, therapy areas and the hand sinks in the dining room. Further review of the facility's policy titled Direct Supply Tels, not dated, revealed the resident room water temperatures should be at 110 degrees F or as specified by state requirements. <p>Observations, on 02/19/14 between 8:51 AM and 10:05 AM, revealed water temperatures in the sinks in eighteen (18) residents' rooms sinks were as follows: room #7 at 98 degrees F, #8 at 96 degrees F, #11 at 64 degrees F, #13 at 92 degrees F, #26 at 99 degrees F, #32 at 99 degrees F, #33 at 95 degrees F, #34 at 94 degrees F, and #35 at 95 degrees F.</p> <p>Observation, on 02/19/14 at 10:42 AM, in the central bath/shower on Hall "A" revealed the water temperature in the shower was 93 degrees</p>	F 253	<p>acceptable range of water temperatures and daily monitoring. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.</p>	

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F 253	Continued From page 8 F. Observation, on 02/19/14 at 11:41 AM in the central bath/shower on Hall "B", revealed the water temperature in the shower was 94 degrees F. Interview, on 02/19/14 at 11:32 AM, with Certified Nurses Aide (CNA) #4 revealed seven (7) showers had been performed on Hall A since 6:30 AM. Review of the Maintenance Water Temperature Logs for the last thirty (30) days revealed the water temperatures were not checked or logged daily throughout the facility. Interview, on 02/19/14 at 11:27 AM, with the Consulting Administrator, revealed he was not aware of the low water temperatures but would call a Plumber to look into the problem. Interview with the Administrator, on 02/20/14 at 10:45 AM, revealed the Maintenance Man had been out of the facility on medical leave since 01/17/14. He revealed the facility did not have a Maintenance Man on duty while he was out.	F 253			
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of	F 258	F258 1. The Administrator noted on 3/19/14 that there were no excessive sound levels in the facility. 2. The Administrator noted on 3/19/14 that there were no excessive sound levels in the facility 3. On 3/17/14 the Regional Director of Operations re-educated the Administrator on the requirement to manage construction in the facility and monitor sound levels to assure sound levels are kept to a minimum and not disrupt the resident environment. 4. The Administrator will interview five (5) residents per month to inquire on sound levels and identify suggestions for improvements. . The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality	3/2/14	

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F 258	<p>Continued From page 9</p> <p>the facility's Lippincott's Textbook for Nursing Assistants, it was determined the facility failed to provide comfortable sound levels during a construction renovation. Multiple areas in the facility suffered water damage and sheet rock repair and replacement. This required the use of a loud commercial dust vacuum. Interviews revealed the noise over several days was disruptive and interrupted activities of daily living and was uncomfortable.</p> <p>The findings include:</p> <p>Review of information in Lippincott's Textbook for Nursing Assistants which the facility used for policy, revealed documentation to include that too much noise can affect the level of comfort of patients and residents. It also revealed that members of the health care team must do their part to keep the noise level to a minimum. Omnibus Budget Reconciliation Act (OBRA) regulations require long-term facilities to take measures to control noise.</p> <p>Interview with the Administrator, on 02/19/14 at 9:30 AM, revealed the facility was having issues with frozen water pipes in the beginning of January 2014. On 01/07/14, plumbers were working in the building to correct the frozen pipes when the water pipes began to burst. The water pipes continued to rupture in different areas at intermittent times over the next few days and water poured down from the ceilings in both of the facility hall areas (A & B Halls) as well as the common area and dining area in the front of the building. Areas of the ceiling began to fall in both the A and B Halls and in the front common area and dining area. Extensive reconstruction was required to remove remaining ceiling areas and</p>	F 258	<p>Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.</p>		

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F 258	<p>Continued From page 10</p> <p>repair the damage. The Administrator revealed construction crews hung dry wall on the ceiling and applied dry wall mud on the seams and joints of the dry wall. Sanding was required between multiple applications of the dry wall mud with the sanding to smooth the seams and joints. A large commercial vacuum utilized for dry wall sanding was used. The purpose of the vacuum was to collect the dust.</p> <p>Interviews during a Group meeting with twelve (12) residents, on 02/19/14 at 11:00 AM, revealed the construction project had been going on for several days. They stated the noise from all the construction, including the loud commercial vacuum woke them up in the mornings and the construction workers worked until after supper most days. The residents stated activities were also disrupted and some had chosen to not attend some activities due to the "racket".</p> <p>Interview with the area Ombudsman, on 02/19/14 at 2:30 PM, revealed she had been in the building several times including 02/10/14 and had talked with ten (10) residents, one staff person and the Administrator. She stated the sound was terrible, there was sanding going on and residents had complained of the noise. She did not recall any resident room doors being shut.</p> <p>Interview with Housekeeping Staff #1, on 02/20/14 at 8:30 AM, revealed during the construction repair there was an abundance of dust and the contractors had a big loud machine to keep the dust down but it did not work well.</p> <p>Interview with the Activity Director, conducted on 02/21/14 at 2:30 PM, revealed there had been residents that did not want to participate in some</p>	F 258			

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F 258	Continued From page 11 activities due to the construction noise and stated the noise had gotten "on my nerves". Interview with the Administrator, on 02/20/14 at 3:00 PM, revealed he had the authority to obtain the contractor services to repair the damage and chose to dry sand (requiring the loud commercial vacuum) the sheet rock instead of the more time consuming wet sanding. He said the project was projected to take two (2) weeks and he had opted to have the contractors work Monday through Friday with weekends off. He recalled the sanding started on 01/10/14 and went on for longer than the projected two (2) weeks as the contractors had just completed their work. He stated no specific actions were taken to try to decrease the noise in the facility.	F 258			
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure it was determined the facility failed to follow its policy and procedure related to clarification and accurately transcribing physician's orders for one (1) of fourteen (14) sampled residents (Resident #14). The facility failed to ensure an order for intravenous fluids (IV) was clarified to include the duration and amount of intravenous fluids to be infused for Resident #14. On 02/06/14, Resident #14 was identified as	F 281	<p><i>F-281</i></p> <ol style="list-style-type: none"> The Director of Nursing notified the physician for resident # 14 on 3/10/14 of the amount and duration of IV fluids given. On 3/10/14 the Director of Nursing notified the physician for resident # 14 of the Trazadone dosage and time frame given with no further directions given. The Director of Nursing, Assistant Director of Nursing, Unit Manager or MDS Nurse completed an audit of all physician orders for the past 30 days of all current resident to assure orders contained all needed components- medication , dose, route, strength, frequency duration or stop date and if prn indication. Any needed clarifications with the physician will be made. This audit and corrections will be completed by 03/11/14. In addition the Director of Nursing, Assistant Director of Nursing, Unit Manager or RN charge nurse will audit all admissions and readmissions in the past sixty (60) days to assure orders were transcribed as ordered. This will be completed by 03/31/14. The physician will be contacted with any discrepancies. All licensed nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Manager related completing physician orders to include medication, dose, 	3/31/14	

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F 281	<p>Continued From page 12</p> <p>having a volume depletion was a high sodium and low potassium level. The physician ordered Dextrose five and one-half percent (5 1/2%) Normal Saline (NS) with 10 milliequivalent (meq) of Potassium (K) at 150 cc/hr (cubic centimeters per hour) after the current bag of NS had completed infusing. However, the order did not specify how much or for how long to infuse the Dextrose 5 1/2 percent NS and the licensed staff failed to clarify the order to include the amount of fluid or the duration to infuse the fluids. The licensed staff infused only one bag of the fluid from 02/06/14-02/07/14. On 02/08/14, the resident was directly admitted to the hospital with a diagnosis of Severe Electrolyte Disturbance with a serum sodium of 177 millimoles/liter (mmol/l) which indicated Dehydration.</p> <p>In addition, the facility failed to transcribe an order for Trazodone accurately and the resident received a higher dose of Trazodone for three (3) months.</p> <p>The findings include:</p> <p>Review of the the facility's policy and procedure titled, New Orders for Non-Controlled Substances, not dated, revealed the facility should ensure all resident information is complete and accurate, has been reconciled and is verified by Physician/Prescriber before faxing or transmitting orders to the pharmacy. The facility should ensure medication orders include medication name, strength, dose, route, frequency, indication for use (to reduce medication errors), and stop order, or administration parameters. Once a Physician/Prescriber has signed the monthly order, a new medication order cannot be added.</p>	F 281	<p>route, strength, frequency or duration stop date or indication . This re-education will be completed by 03/31/14 with no licensed staff working after 03/31/14 without having received this re-education. All Licensed Nurses will be educated on the verification of admission orders or readmission orders by two nurses. This education will be completed by the Director of Nursing, Assistant Director of Nursing, Unit Manager or RN Charge Nurse by 03/31/14 with no Licensed Nurse working after 03/31/14 without having received this education.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review five (5) resident records per week for twelve(12) weeks to assure orders are written correctly to include medication, dose, route, strength, frequency or duration, stop date or indication for as needed medications as well as all admissions and readmissions weekly for twelve (12) weeks to assure orders were transcribed correctly. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.</p>		

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F 281	<p>Continued From page 13</p> <p>In this situation, an interim order form or telephone order form should be completed for additional medication orders.</p> <p>Record review revealed the facility admitted Resident #14 on 07/01/12 with diagnoses which included Alzheimer's Disease, Diabetes Mellitis, Dysphagia, and Hypothyroidism.</p> <p>Review of a Laboratory Report, dated 02/06/14, revealed Resident #14's Blood Urea Nitrogen (BUN) was 76 mg/dl (normal 7-22); Sodium was 167 mmol/l (normal 136-146); and, Potassium was 2.8 mmol/l (normal 3.3-5.5).</p> <p>Review of the Physician's Order, dated 02/06/14, revealed staff should infuse Dextrose five and one-half percent (5 1/2%) NS with 10 meq of potassium at 150 cc/hr after the current bag of NS had completed infusing. The order did not specify how much or for how long to infuse the Dextrose 5 1/2 percent NS. Further review of the Physician's Order revealed there was no order clarifying the 02/06/14 intravenous order for the amount of fluid or the duration to infuse the fluids.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 02/22/14 at 11:00 AM, revealed on 02/06/14 she received an order from the physician to change the intravenous fluids from NS to D 5 1/2 NS with 10 meq of K to begin after the current bag of IV fluids infused due to a laboratory report that showed the resident's potassium was depleted. The LPN revealed the resident received one (1) bag of the D 5 1/2 meq with K which was administered on 02/06/2014. LPN #4 stated she failed to clarify the total amount of fluids to infuse or the duration of the order with the resident's physician.</p>	F 281		

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F 281	<p>Continued From page 14</p> <p>Review of the Nurse's Notes, dated 02/08/14 at 10:28 PM, revealed the resident's son spoke to the nurse stating he wished to speak to the resident's physician. The nurse called the physician and gave the phone to the son. The resident was very lethargic and the following vital signs were obtained: temperature: 97.6 degrees Fahrenheit (F)(normal 97.5), heart rate 101 (normal 80s), respirations 20 (normal 20) and blood pressure 130/78 (normal around 172/74) and a oxygen saturation level of 92 % (normal 95-96 %). The physician gave an order to direct admit the resident to the hospital.</p> <p>Interview, on 02/20/14 at 12:42 PM, with Resident #14's family member revealed Resident #14 had IVs ordered due to his/her declining status on Wednesday, 02/05/14; and, when they visited him/her on 02/07/14, the IV had been discontinued. The family member stated he/she phoned the physician on 02/08/14 to inform him of Resident #14's status and was told that was why the IV fluids had been ordered. The family member stated he/she informed the physician that Resident #14 had not had an IV since 02/06/14 and the resident had only received the IV fluids for 24 hours. The family member stated the physician ordered the resident to be directly admitted to the hospital.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 02/22/14 at 11:00 AM, revealed the physician ordered NS IV at 75 cc/hr per pump x three (3) liters; and, on 02/06/14 the physician changed the order to NS to D 5 1/2 NS with 10 meq K to begin after the current bag of IV fluids infused. LPN #4 stated she failed to clarify the duration of the order with the resident's physician and only</p>	F 281			

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F 281	<p>Continued From page 15</p> <p>infused one bag of NS D 5 1/2 NS with 10 meq. of K.</p> <p>Review of the hospital's History and Physical, dated 02/08/14, revealed Resident #14 was admitted to the hospital on 02/08/14 with an impression of Severe Electrolyte Disturbance with a serum sodium of 177 mmol/l indicating Dehydration.</p> <p>Interview with the Physician, on 02/21/14 at 11:00 AM, revealed he had ordered D 5 1/2 NS with 10 meq of K and had intended for the fluids to be continuous. He stated he would have expected the nurse to clarify the order before discontinuing the fluids especially due to the resident's already fragile state.</p> <p>Interview with the Director of Nursing, on 02/21/14 at 9:30 AM, revealed LPN #4 should have clarified the order to ensure the correct total amount of fluids were administered or the fluids were administered for the intended duration.</p> <p>Interview with the Administrator, on 02/22/14 at 9:40 AM, revealed he expected the nurse to clarify an order that did not specify an end date.</p> <p>2. Further review of Resident #14's November 2013 Physician orders revealed an order for Trazodone (antidepressant) 50 milligrams (mg) at 3:00 PM and 50 mg at bedtime.</p> <p>Review of a Psychiatric Follow-up Evaluation, dated 10/31/13, revealed a dose reduction was recommended to reduce the Trazodone to 25 mg at 3:00 PM and 50 mg at bedtime.</p> <p>Review of physician's order, dated 11/01/13,</p>	F 281			

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F 281	<p>Continued From page 16</p> <p>revealed to administer Trazodone 25 mg at 3:00 PM and 50 mg at bedtime. Further review of the November 2013 Medication Administration Record (MAR) revealed the order was changed to reflect the decrease in the Trazodone dosage.</p> <p>Record review revealed Resident #14 was admitted to the hospital on 11/12/13 and was readmitted to the facility on 11/19/13. Review of the hospital physician's orders revealed the resident was to continue on the Trazodone 25 mg at 3:00 PM and 50 mg at bedtime. However, review of the facility's physician order revealed the nurse transcribed the order incorrectly as Trazodone 50 mg at 3:00 PM and 50 mg at bedtime. Review of the December 2013, January and February 2014 physician orders and MARs revealed the resident continued to receive the incorrect dose of Trazodone for three (3) months which was a significant medication error.</p> <p>Interview with the DON, on 02/22/14 at 1:40 PM, revealed the nurse was supposed to transcribe the readmission orders onto the facility's physician's order. In addition, the Pharmacist should review the medications on a monthly basis and ensure the orders had been transcribed correctly. She stated she did not know how this could have happened.</p> <p>Interview with the Administrator, on 02/22/14 at 9:40 AM, revealed it was his expectation for two (2) nurses to sign off on the admission/readmission orders and pharmacy should check all orders each month against the original order to ensure accuracy.</p> <p>Interview with the Physician, on 02/21/14 at 11:00 AM, revealed he had ordered the gradual dose</p>	F 281		

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F 281	Continued From page 17 reduction and he would have expected the facility to follow the orders correctly.	F 281			
F 323 -SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. Electrical outlets were left without covers after major construction was completed inside the facility. The facility failed to ensure ladders were not left out in areas the residents were in and failed to ensure dust from sanding was contained so the resident's were not breathing it in the air. In addition, the facility failed to ensure staff transfilled the portable Oxygen cylinder with liquid Oxygen in a safe manner. The findings include: 1. Observations, on 02/19/14, 02/20/14, 02/21/14, and 02/22/14, in the main dining room revealed two (2) light switches and eight (8) electrical outlets with wiring exposed and no protective coverings noted.	F 323	F323 1. The Director of Nursing observed CNA# 4 transfilling oxygen on 3/10/14 and noted CNA# 4 was transfilling O2 with the door closed. CNA# 4 was re-educated by the Director of Nursing on 3/10/14 on transfilling O2. On 3/14/2014 the Administrator observed that no ladders were in use including the alcove by the nurses' station and the main hallways. The facility obtained air filtration systems on 2/21/2014 and addition housekeeping staff and the Administrator noted that all sanding dust was removed from the facility by 2/24/2014. The Administrator noted on 2/24/2014 that there was no dust in the facility to include the loveseat and chair in common area, furniture in lobby, paper towel holder in the bathroom, sharps container and med carts. The black substance between the nurses station and copy room will be removed by 3/28/14. The identified light covers (2) and electrical outlet covers (8) in the dining room were repaired or replaced by the Maintenance Supervision on. On 3/17/2014 the Administrator noted that the two (2) light covers and eight (8) electrical outlet covers had been replaced or repaired.	3/31/14	

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F 323	<p>Continued From page 18</p> <p>Interview with the Administrator on 02/22/14 at 9:40 AM, revealed the exposed outlets and light switches could potentially be a hazard and it would be his expectation for the contracted workers to have replaced the face plates/cover plates to the light switches/electrical outlets. He further stated that he should have ensured that they were replaced.</p> <p>2. Observation during the initial tour of the facility, on 02/19/14 at 8:28 AM revealed:</p> <p>A. a black build-up on the wall in the commons area between the nursing station and copy room.</p> <p>B. a large white dust build-up on the tops of the love seats and chairs in the common sitting area.</p> <p>C. a build up of white dust on the furniture in the main lobby and in bathroom on the paper towel holder.</p> <p>D. a large white build up on top of a water pitcher on the medication cart outside the door of room #33. The sharps container on the side of the cart also had a large white build up.</p> <p>E. Observation of the alcove in the commons area next to the nursing station revealed two (2) aluminum ladders standing against the wall. This area was fully exposed to residents.</p> <p>3. Observation of the main hallway between Hall "B" nursing station and the copy room, on 02/20/14 at 12:03 PM, revealed a ladder standing freely against the wall unsupervised. This area was fully exposed to the residents.</p> <p>A group meeting was conducted on 02/19/14 at 11:00 AM. Residents #1, #4 and #11 in the selected sample and additional residents (#E, #F,</p>	F 323	<p>2. On 3/14/14 the Administrator observed that no ladders were in use. The facility obtained addition housekeeping staff on 2/21/14 and all dust was removed from the facility. On 2/24/14 the Administrator noted that there was no dust in the facility. By 3/28/14 the Administrator will complete an audit of the facility walls to determine any "black stuff" that needs to be removed and any identified will be removed by 3/28/14. On 03/14/14 an environmental tour was completed by the Administrator to identify any environmental hazards, any identified hazards were immediately corrected. On 03/10/2014 the Director of Nursing observed transfilling of Oxygen and noted that the transfilling was occurring with the door closed. An audit of all electrical outlet covers and light switch covers was completed by the Administrators any needing repair or replacement will be repaired or replaced by 03/31/14.</p> <p>3. All nursing staff will be re-educated on the transfilling of oxygen to include closing the door. This education will be completed by the Director of Nursing, Assistant Director of</p>	

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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 02/22/2014
NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
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F 323	<p>Continued From page 19</p> <p>#G, #H, #J, #K, #L and #M) were in attendance. The residents revealed the construction started in early January and lasted through the end of February. The residents stated the dust was causing them to cough and it was hard to breath. The residents revealed meals were served in the dining area before construction was completed and the air was dusty and there were ladders, paint cans and drop cloths in the area where they were eating.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 02/17/14 at 9:30 AM, revealed the dust and paint fumes related to the construction was very hard to work in.</p> <p>Interview with the Consulting Administrator, on 02/20/14 at 12:03 PM, revealed staff should not leave ladders standing in the hallway unsupervised.</p> <p>Interview with the Administrator, on 02/22/14 at 9:45 AM, revealed he was responsible to ensure the safety and well being of all residents. The Administrator stated he called the corporate office on 02/08/14, when ruptured water pipes in the ceiling was causing major damage, and was told to "do what you need to do". He stated he made the decision to have the construction workers to dry sand the sheet rock repair, which caused more dust, instead of wet sanding in which there would have been less dust but would have taken more time.</p> <p>4. Review of facility policy, titled Oxygen Therapy and Devices, dated 02/2013, revealed oxygen is a drug which must be ordered by a physician and oxygen is a flammable gas that supports combustion. The policy revealed Liquid Oxygen is stored at -297 F and a portable unit must rest</p>	F 323	<p>Nursing, Unit Manager or RN charge nurse with no staff working after 3/31/14 without having received this re-education. All Housekeeping staff will be re-educated by the housekeeping supervisor on the cleaning schedule by 3/31/14. The Maintenance Director will be re-educated on the identification of hazards during construction and identification of repairs by the Administrator by 3/31/14. The Administrator will be re-educated by the Regional Director of Operations on the scheduling and oversight of construction by 03/28/14.</p> <p>4. The Administrator will conduct weekly audits for twelve (12) weeks of the environment to identify environmental hazards to include cleanliness, dust, and disrepair electrical and light covers as well as ladders and repair hazards. The Director of Nursing, Assistant Director of Nursing, or Unit Manager will observe the transfilling of liquid oxygen five (5) times per week for twelve (12) weeks to assure staff are closing the door. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.</p>		

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F 323	<p>Continued From page 20</p> <p>for twenty minutes following a fill for optimal flow rate delivery.</p> <p>Observation on 02/21/14 at 9:50 AM revealed Certified Nurse Aide (CNA) #4 identified Resident #6's oxygen concentrator was not functioning and the regulator revealed there was no oxygen was being delivered by the concentrator. CNA #4 went to the oxygen therapy room and filled a portable oxygen tank as there were no replacement concentrators. The door to the oxygen storage room was held open by the CNA as she filled the portable tank.</p> <p>Interview with CNA #4, on 02/21/14 at 10:00 AM, revealed she had received training on filling portable oxygen tanks from another CNA and a nurse. She stated the door to the oxygen storage room had to be left open when filling oxygen tanks from the liquid oxygen tanks. She transferred oxygen therapy equipment for residents routinely as well as transfilling of portable oxygen tanks.</p> <p>Interview conducted with a Respiratory Therapist (RT), on 02/21/14 at 10:15 AM, revealed he provided weekly service to all resident oxygen equipment. The RT stated he had observed CNA #4 transfill the portable oxygen tank from the liquid oxygen tank and said the door to the storage room should have been closed during the transfilling. He additionally stated he had provided training related to transfilling from liquid oxygen tanks to the facility in the past.</p> <p>Interview with the Director of Nursing (DON), on 02/21/14 at 11:10 AM, revealed staff could transfill portable oxygen tanks from the liquid oxygen tanks if they had been trained. Additional</p>	F 323			

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F 323	Continued From page 21 interview with the DON on 02/22/14 at 11:05 AM revealed there was no verification CNA #4 had been trained related to transfilling of liquid oxygen and the facility had not been ensuring the staff were trained.	F 323			
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure it was determined that the facility failed to ensure one (1) of fourteen (14) sampled residents (Resident #14) was free of significant medication errors related to intravenous (IV) fluids not administered for the correct amount; and, an incorrect dose of Trazodone (antidepressant) administered for three (3) months. On 02/05/15, Resident #14 began showing symptoms of an infection. The physician was made aware and orders were received to infuse three (3) liters of Normal Saline (NS) intravenously. On 02/06/14, laboratory results were received that indicated Resident #14's sodium and potassium were at critical levels. The physician was notified and orders were received to infuse Dextrose five and a half percent (D 5 1/2%) NS with 10 milliequivalent (meq) of Potassium (K) at 150 cc/hr after current bag of IV fluids was infused. The physician's order did not specify the total amount or duration	F 333	1. The Director of Nursing notified the physician for resident # 14 on 3/10/14 of the amount and duration of IV fluids given. On 3/10/14 the Director of Nursing notified the physician for resident # 14 of the Trazadone dosage and time frame given with no further directions given. 2. The Director of Nursing, Assistant Director of Nursing, Unit Manager or MDS Nurse completed an audit of all physician orders for the past 30 days of all current resident to assure orders contained all needed components- medication , dose, route, strength, frequency duration or stop date and if pri indication. Any needed clarifications with the physician will be made. This audit and corrections will be completed by 03/11/14. In addition the Director of Nursing, Assistant Director of Nursing, Unit Manager or RN charge nurse will audit all admissions and readmissions in the past sixty (60) days to assure orders were transcribed as ordered. This will be completed by 03/31/14. The physician will be contacted with any discrepancies. 3. All licensed nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Manager related completing physician orders to include medication, dose,	3/31/14	

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F 333	<p>Continued From page 22</p> <p>for infusing the intravenous fluids, and the nurse failed to clarify the order to ensure the correct amount of intravenous fluid was infused. Resident #14 received one (1) liter of D 5 1/2% NS. On 02/08/14, the physician was made aware by the family that IV fluids had not been administered since 02/06/14. The physician gave an order to have the resident directly admitted to the hospital. Resident #14 was admitted to the hospital and diagnosed with Severe Electrolyte Disturbance with a serum sodium of 177 indicating volume depletion (dehydration).</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, New Orders for Non-Controlled Substances, not dated, revealed the facility should ensure all resident information is complete and accurate, has been reconciled and is verified by the Physician/Prescriber before faxing or transmitting orders to the pharmacy. The facility should ensure medication orders include medication name, strength, dose, route, frequency, indication for use (to reduce medication errors), a stop order, or administration parameters. Once a Physician/Prescriber has signed the monthly order, a new medication order cannot be added. In this situation, an interim order form or telephone order form should be completed for additional medication orders.</p> <p>1. Record review revealed the facility admitted Resident #14 on 07/01/12 with diagnoses which included Alzheimer's Disease, Diabetes Mellitus, Dysphagia, and Hypothyroidism.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/19/14 revealed the</p>	F 333	<p>route, strength, frequency or duration stop date or indication . This re-education will be completed by 03/31/14 with no licensed staff working after 03/31/14 without having received this re-education. All Licensed Nurses will be educated on the verification of admission orders or readmission orders by two nurses. This education will be completed by the Director of Nursing, Assistant Director of Nursing, Unit Manager or RN Charge Nurse by 03/31/14 with no Licensed Nurse working after 03/31/14 without having received this education.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review five (5) resident records per week for twelve (12) weeks to assure orders are written correctly to include medication, dose, route, strength, frequency or duration, stop date or indication for as needed medications as well as all admissions and readmissions weekly for twelve (12) weeks to assure orders were transcribed correctly. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.</p>		

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F 333	<p>Continued From page 23</p> <p>facility assessed Resident #14 to have severe cognitive impairment.</p> <p>Review of the Nursing Notes, dated 02/05/14 at 4:56 PM for 8:30 AM, revealed Resident #14 was moaning when touched, unresponsive to name, skin was warm to touch and lung sounds were diminished. The resident was very lethargic. There was a greenish discharge noted from the resident's eyes. The physician was notified and orders were received for an antibiotic intramuscularly times one (1), an antibiotic orally daily, a urinalysis (UA) and culture and sensitivity (C & S). The resident's family was made aware. Further review of the Nurse's Notes, dated 02/05/14 at 7:26 PM, and a physician's order, dated 02/05/14, revealed orders were received to start intravenous fluids of NS at 75 ml/hr per pump times three (3) liters.</p> <p>Review of the Nurse's Notes, dated 02/06/14 at 7:03 AM, revealed the resident continued to moan, was non-responsive to name, respirations were diminished and a congested cough was noted at times. At 8:00 AM, the son was at the bedside and it was difficult to arouse the resident to eat breakfast. The physician was notified and orders were received for a Complete Blood Count (CBC) and Basis Metabolic Profile (BMP). At 2:59 PM, the lab results were received and there were critical values for a high sodium and low potassium. Review of a Laboratory Report, dated 02/06/14, revealed Resident #14's Blood Urea Nitrogen (BUN) was 76 milligrams/deciliter (mg/dl) (normal 7-22); Sodium was 167 millimoles per liter (mmol/l) (normal 136-146); and, Potassium was 2.8 mmol/l (normal 3.3-5.5)</p>	F 333			

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F 333	<p>Continued From page 24</p> <p>Review of a Physician's Order, dated 02/06/14, revealed an order for a "Chem 7" and staff should start Dextrose five and a half percent (5 1/2%) NS with 10 meq of K at 150 cc/hr after the current bag of IV fluids was infused. However, the physician's order did not indicate the total amount of IV fluids to infuse or the duration to infuse the IV fluids. Further review revealed no documented evidence the licensed staff clarified the order to ensure the resident received the intended amount of fluids the physician wanted to order.</p> <p>Further review of the Nurse's Notes, dated 02/07/14 at 5:33 AM, revealed the bag of 1/2 NS with 10 meq of Potassium had infused and the IV was converted to a heparin lock.</p> <p>Review of the Nurse's Notes, dated 02/08/14 at 10:22 PM for 5:30 PM, revealed Resident #14's son wanted to speak to the physician. The nurse called the physician and the son explained to him about the resident's IV fluids. The physician ordered the resident to be sent to the hospital as a direct admission.</p> <p>Interview with Resident #14's Family Member, on 02/20/14 at 12:42 PM, revealed Resident #14's physician had ordered the IVs due to the resident's inability to take in fluids and his/her declining status; on Wednesday, 02/05/14; and when they visited him/her on 02/07/14, the IV had been discontinued. The family member stated they phoned the physician on 02/08/14 to inform him of Resident #14's status and was told that was why the IV fluids had been ordered. The Family Member revealed after they spoke with the physician, the physician ordered for the resident to be admitted to an acute care hospital. The Family Member stated Resident #14 was</p>	F 333			

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F 333	<p>Continued From page 25</p> <p>discharged from the acute care hospital to Hospice on 02/19/14 and he/she was receiving comfort measures only.</p> <p>Review of the hospital History and Physical, dated 02/08/14, revealed Resident #14 was admitted on 02/08/14 with a diagnosis of Severe Electrolyte Disturbance with a serum sodium of 177 indicating volume depletion.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 02/22/14 at 11:00 AM, revealed Resident #14 normally went to the dining room and normally would eat and drink approximately seventy-five (75) percent of his/her meals. The LPN stated on 02/05/14, the resident was difficult to arouse and had a greenish drainage coming from both eyes. The LPN stated the physician ordered NS IV at 75 cc/hr per pump x three (3) liters; and, on 02/06/14 the physician changed the order from NS to D 5 1/2 NS with 10 meq K to begin after the current bag of IV fluids infused. LPN #4 stated she failed to clarify the duration of the order with the resident's physician and only infused one bag of NS D 5 1/2 NS with 10 meq. of K.</p> <p>Interview with the Director of Nursing, on 02/21/14 at 9:30 AM, revealed she expected LPN #4 to have clarified the order to obtain the intended duration of the infusion of the IV fluids.</p> <p>Interview with the Physician, on 02/21/14 at 11:00 AM, revealed he ordered D 5 1/2 NS with 10 meq of K and had intended for the fluids to be continuous. He stated he would have expected the nurse to clarify the order before discontinuing the fluids especially due to the resident's already fragile state.</p>	F 333			

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F 333	<p>Continued From page 26</p> <p>Interview with the Administrator, on 02/22/14 at 9:40 AM, revealed he expected the nurses to clarify orders when they do not state the duration or total amount of the medication to be administered.</p> <p>2. Further review of Resident #14's physician orders revealed an order for Trazodone (antidepressant) 50 mg at 3:00 PM and 50 mg as bedtime.. Review of a Psychiatric Follow Up Evaluation, dated 10/31/13, revealed the Psychiatrist recommended a dose reduction of the Trazodone to 25 mg at 3:00 PM and 50 mg at bedtime. Review of the Physician's orders, dated 11/01/13, revealed the Trazodone was reduced to 25 mg at 3:00 PM and Trazodone 50 mg. at bedtime.</p> <p>Review of Physician's Orders from a hospital readmission to the facility, dated 11/19/13, revealed the resident was to continue the Trazodone 25 mg at 3:00 PM and 50 mg at bedtime. However, review of the facility's Admission Orders, dated 11/19/13, revealed the Trazodone order was transcribed as Trazodone 50 mg at 3:00 PM and 50 mg at bedtime. Further review of the December 2013, January 2014 and February 2014 Medication Administration Records (MARs) revealed the resident received the higher dose of Trazodone for three (3) months which was a significant medication error.</p> <p>Interview with the DON, on 02/22/14 at 1:40 PM, revealed the nurse transcribes the admission and readmission orders onto the facility's physician's order and the pharmacist reviews the medications on a monthly basis to identify any inconsistencies. She stated she expected the Pharmacist to review the orders against the</p>	F 333			

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F 333	Continued From page 27 original order. She stated she was not sure how this happened.	F 333			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure food was prepared and served under sanitary conditions. Temperature thermometers were missing from a refrigerator and one refrigerator had a non functioning thermometer. Areas in the kitchen as well as the food rolling carts were covered in a thick coat of dust. Review of the Census and Condition, dated 02/19/14, revealed the facility had a census of fifty-six (56) residents and only three (3) residents received tube feedings. Fifty-three (53) residents	F 371	F371 1. On 02/19/14 a thermometer and temperature log was placed in the two door reach-in refrigerator by the Dietary Service Manager and temperatures were noted to be adequate. On 02/19/14 the Dietary Service Manager replaced the thermometer in the milk cooler and the temperatures were noted to be adequate. On 03/10/14 the floor of the dry storage area was cleaned and noted to be free of any sticky residue by the Administrator. On 03/17/14 the shelves in the dish room were cleaned and noted by the Dietary Service Manager to be free of dust. On 03/13/14 the sprinkler lines in the kitchen were cleaned by housekeeping services and noted by the Dietary Service Manager on 03/17/14 to be free of dust. On 03/13/14 the electrical cord for the place warmer was cleaned by housekeeping services and noted by the Dietary Service Manager to be free of dust on 03/17/14. On 03/17/14 the Dietary Service Manager noted the rolling food carts to be clean and free of dust. 2. On 03/13/14 Healthcare Services conducted deep cleaning of the kitchen. On 03/14/14 the Administrator completed a sanitation audit of the kitchen, kitchen dry storage and food carts to identify any other	3/31/14	

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F 371	Continued From page 28 In the facility received their meals from the facility's kitchen. The findings include: Review of the Nutrition Services Cleaning Schedule, not dated, revealed the food carts were to be cleaned after each use and the pot and pan shelf was to be cleaned two (2) times a week. 1. An initial tour of the kitchen on 02/19/14 completed at 9:20 AM revealed: A. Observation of the two (2) door reach in refrigerator revealed there was no thermometer present and there was no temperature log. B. Observation of the milk cooler revealed the thermometer was broken and not functional. C. Observation of the dry storage area revealed the floor had a build up of sticky residue over the floor causing a sticking sound when walked across. D. Observation of the dish washing room revealed a wall shelf for clean dishes and pans that was covered in a buildup of thick grey dust. E. Observation of the sprinkler line running the length of the kitchen and over the stove and food preparation area had a build up of grey colored dust. 2. Observation of the noon meal tray line, on 02/19/14 at 11:30 AM, revealed the electric cords from the plate warmer went to the ceiling plug located just over the steam table. The cords had a build up of dust on them. Each time the kitchen	F 371	cleaning needs and any identified cleaning needs was immediately corrected. On 03/13/14 the Dietary Service Manager completed an audit of all temperature logs and thermometers to assure all were working appropriately and temperatures adequate with logs in place. No concerns were identified. 3. The Dietary Service Manager will complete re-education of all kitchen staff related to the cleaning schedule, use of temperature logs and working thermometers by 03/28/14 with no Dietary staff working after 03/28/14 without having received this re-education. The Administrator will educate the Maintenance Director by 03/28/14 on the high cleaning schedule for the kitchen staff. 4. The Dietary Service Manager and Administrator will conduct weekly sanitation audits of the kitchen, dry food storage area and food carts as well as audit temperature logs and thermometers to assure the kitchen, food carts and dry storage area is clean and sanitary and that all refrigerators have working thermometers and temperatures are adequate. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending		

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F 371	Continued From page 29 staff reached for a warmer plate and cover she touched the electric cords causing dust to fall. 3. Observation during the noon meal, on 02/19/14 at 12:25 PM, revealed a rolling food cart sitting on the hall outside the kitchen area had a large build up of grey dust on it. A basket of condiments was sitting on top the cart. Further observation revealed another rolling food cart that was being used to serve the lunch meal on the "A" Hall had a thick build up of dust on top of the cart. Interview with the Dietary Manager, on 02/19/14 at 9:20 AM, revealed the refrigerators should have working thermometers and areas in the kitchen had scheduled cleaning times. She gave no explanation as to why there was a large build up of dust on the shelf and rolling carts. Further interview with the Dietary Manager, on 02/21/14 at 10:00 AM, revealed maintenance was responsible to keep the sprinkler lines and other areas up high in the kitchen, cleaned.	F 371	at least quarterly. F428 1. On 3/10/14 the Director of Nursing notified the physician for resident # 14 of the Trazadone dosage and time frame given with no further directions given. 2. The Director of Nursing Assistant Director of Nursing or Unit Manager will audit all admissions and readmissions in the past sixty (60) days to assure orders were transcribed as ordered. This will be completed by 03-31-2014. The physician will be contacted with any discrepancies. 3. On 03/31/2014 the Director of Nursing re-educated the pharmacy consultant on the verification of accuracy admission orders or readmission orders if a resident returns or admits during the prior month, as part of her chart review.	3/31/14	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428			

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F 428	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the Pharmacist identified a drug irregularity for one (1) of fourteen (14) sampled residents (Resident #1). The Pharmacist failed to identify Resident #1's Trazodone order was transcribed incorrectly which resulted in the resident receiving a higher dose of Trazodone than ordered for approximately three (3) months.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure for "Medication Regimen Review", dated 12/01/07, revealed the Consultant Pharmacist should conduct a Medication Regimen Review (MRR). The facility must ensure the Consultant Pharmacist has access to: the resident, and/or resident's responsible party, resident's records, laboratory tests, physician/prescriber progress notes, nurse's notes, and other documents which may assist the Consultant Pharmacist in making a professional judgement as to whether or not irregularities exist in the medication regimen.</p> <p>Record review revealed the facility admitted Resident #14 on 07/01/12 with diagnoses which included Alzheimer's Disease, Diabetes Mellitus, Dysphagia, and Hypothyroidism.</p> <p>Review of Physician's Orders from a hospital readmission to the facility, dated 11/19/13, revealed Resident #14 was to continue to receive Trazodone (antidepressant) 25 milligrams (mg) at 3:00 PM and 50 mg at bedtime. However, review of the facility Admission Orders, dated 11/19/13, revealed the Trazodone order was transcribed as</p>	F 428	<p>4. The Director of Nursing, Assistant Director of Nursing, or Unit Manger will audit five (5) readmissions or admissions monthly for three (3) months to assure the pharmacy included an evaluation of admission or readmission orders for accuracy. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.</p>		

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F 428	<p>Continued From page 31</p> <p>Trazodone 50 mg at 3:00 PM and 50 mg at bedtime which was 25 mg more than ordered by the physician for the 3:00 PM dose.</p> <p>Review of the November and December 2013; and, January and February 2014 Medication Administration Records (MARs) revealed the resident received the Trazodone 50 mg at 3:00 PM and at bedtime daily.</p> <p>Review of the November 2013 and December 2013; and, January and February 2014 MRRs revealed there was no documented evidence the Pharmacist had identified the drug irregularity.</p> <p>Interview with the Consultant Pharmacist who conducted the MRR in November -December 2013, on 03/24/14 at 11:45 AM, revealed she conducted a MRR monthly on every active resident in the facility. She stated she reviewed the resident's diagnoses and physician orders to ensure there were no unnecessary medication; reviewed to ensure labs were ordered and obtained according to the resident's diagnoses and ordered medications; and, reviewed the physician's orders and MARs to ensure the orders were transcribed correctly. She stated when a resident was admitted or readmitted from the hospital she would have checked for any medication changes and would have ensured the new orders were transcribed correctly. She stated if she failed to identify the transcription error in this situation she would guess it was because she missed it as she knows she would have looked at the hospital orders, physician orders and MAR to ensure transcribed correctly.</p> <p>Interview with the Director of Nursing, on 02/22/14 at 1:40 PM, revealed she expected the</p>	F 428			

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F 428	Continued From page 32 Pharmacist to review the orders against the original order and to have identified the irregularity. Interview with the Administrator, on 02/22/14 at 9:40 AM, revealed the Pharmacist should have identified the error when they completed the monthly checks.	F 428	F464 1. On 02/22/14 the Dining Room and Lobby was reopened for meals and activities. The Administrator noted on 02/22/14 that meals were served in the Dining Room and activities were occurring in the Dining Room and Lobby.	3/21/14
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on interviews and a Resident Group Meeting, it was determined the facility failed to ensure it provided adequate space for dining and activities related to a large construction renovation project that included the dining and common areas of the facility as well as most of both the A and B Halls that lasted from early January until the last of February. The findings include: A Resident Group Meeting was conducted on 02/19/14 at 11:00 AM. Residents #1, #4 and #11 in the selected sample and additional residents (#E, #F, #G, #H, #J, #K, #L and #M) were in attendance. The residents revealed the	F 464	was reopened for meals and activities. The Administrator noted on 02/22/14 that meals were served in the Dining Room and activities were occurring in the Dining Room and Lobby. 3. On 03/17/14 the Regional Director of Operations re-educated the Administrator on the requirement to maintain adequate dining and activity space during construction and to schedule repairs of these areas to accommodate the resident needs. 4. The Administrator will audit meals and activities weekly for twelve (12) weeks to assure that meals and activities are occurring in appropriate space. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.	

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F 464	<p>Continued From page 33</p> <p>construction started in early January and lasted through the end of February. The residents stated some of the time they stayed in their rooms and some activities were provided in their rooms on some of the days. The residents revealed there were a few activities that were conducted in the employee break room and in the facility conference room but only a few residents could attend those activities as the rooms did not accommodate all the residents that utilized wheelchairs. Some of the residents stated the noise was unbearable and the dust was causing them to cough and it was hard to breath. The residents revealed meals were served in the dining area before construction was completed and the air was dusty and there were ladders, paint cans and drop cloths in the area where they were eating.</p> <p>Interview with the Activity Director, on 02/21/14 at 2:30 PM, revealed no activities were canceled due to the construction even though the conditions were not ideal. She stated she offered one on one activities in the residents' rooms and used the conference room and employee break room. All of the residents that usually participated in activities could not all fit in the conference room or employee break room. She revealed some residents chose not to participate due to the construction noise and that the noise had gotten on their "nerves".</p> <p>Interview with the Administrator, on 02/22/14 at 9:45 AM, revealed he had hired a part time activities person for 2:00 PM till 4:00 PM Monday through Friday. He stated he made conference room available and knew some activities had been held in there. He stated the conference room was appropriate for small groups but not</p>	F 464			

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F 464	Continued From page 34	F 464			
F 468 SS=E	<p>large groups. The Administrator stated he thought the housekeeping staff failed at keeping the dining area clean from the construction dust on the days the residents did utilize those areas.</p> <p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that corridors were equipped with handrails on each side of each hall for two (2) of two (2) halls in the facility.</p> <p>The findings include:</p> <p>Observation, on 02/19/14 at 8:25 AM, revealed there were no handrails secured to the wall on either side of the walls on halls A and B.</p> <p>Interview with Resident #4, on 02/19/14 at 11:00 AM, revealed hand rails on the walls in the hall area was how he/she propelled him/herself from one destination to another. Resident #4 stated he/she had to wait for someone to push him/her in the wheelchair since the handrails were absent and it "makes me feel downhearted" when he/she had to depend on someone else to take him/her to his/her destination.</p> <p>Interview with the Administrator, on 02/22/14 at 9:42 AM, revealed he knew of the absence of hand rails and the handrails were used by</p>	F 468	<p>F468</p> <p>1. The Administrator observed on 02/20/14 that the handrails had been replaced and all hallways had handrails on each side.</p> <p>2. The Administrator observed on 02/20/14 that the handrails had been replaced and all hallways had handrails on each side</p> <p>3. On 03/17/14 the Administrator was re-educated by the Regional Director of Operations on the requirement of handrails on all resident hallways and both sides.</p> <p>4. The Administrator will audit all hallways weekly for twelve (12) weeks to assure that handrails are in place on both sides. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.</p>	3/31/14	

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F 468	Continued From page 35 residents as safety enablers to pull themselves in wheelchairs, ambulate, and to steady self. The Administrator stated the handrails were taken down on 02/13/14 due to painting at the facility and they were not put back up until 02/20/14.	F 468	F490 1. The Regional Director of Operations on 03/17/14 noted that the Administrator was providing oversight in the facility that enabled the facility to use its resources effectively and efficiently to maintain or attain the resident's highest mental, physical or psychosocial wellbeing. The Regional Director of Operations noted that the Administrator was managing the facility resources including any maintenance or repairs effectively.	3/31/14	
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of Administrator Job Description it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure a safe and comfortable environment while construction was conducted inside the facility. The noise and dust in the facility from the beginning of January 2014 through the end of February 2014 affected residents daily living. In addition, repeated Life Safety Code deficient practice was identified: The findings include: Review of the Administrator's job description, dated 2003, revealed "The primary purpose of your job position is to direct the day-to-day	F 490	2. The Regional Director of Operations on 03/17/14 noted that the Administrator was providing oversight in the facility that enabled the facility to use its resources effectively and efficiently to maintain or attain the resident's highest mental, physical or psychosocial wellbeing. The Regional Director of Operations noted that the Administrator was managing the facility resources including any maintenance or repairs effectively. 3. On 03/17/14 the Regional Director of Operations educated the Administrator on the requirements and job description of the Administrator to manage the facility in a manner that meets the federal and State guidelines as well as communication and scheduling of any construction so as to not affect the residents daily routine.		

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F 490	<p>Continued From page 36</p> <p>functions of the facility in accordance with current Federal, State and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times".</p> <p>Interview with the Administrator, on 02/22/14 at 9:45 AM, revealed he was responsible to ensure the safety and well being of all residents. The Administrator stated he called the corporate office on 02/08/14, when ruptured water pipes in the ceiling was causing major damage, and was told to "do what you need to do". He stated he made the decision to have the construction workers to dry sand the sheet rock repair, which caused more dust and noise, instead of wet sanding in which there would have been less dust but would have taken more time.</p> <p>Interview during a group meeting with twelve (12) residents, on 02/19/14 at 11:00 AM, revealed the construction project had been going on for several days. They stated the noise from all the construction, including the loud commercial vacuum woke them up in the mornings and the construction workers worked until after supper most days. The residents stated activities were also disrupted and some had chosen to not attend some activities due to the "racket".</p> <p>Interview with the area Ombudsman, on 02/19/14 at 2:30 PM, revealed she had been in the building several times including 02/10/14 and had talked with ten (10) residents, one staff person and the Administrator. She stated the sound was terrible, there was sanding and painting going on and residents had complained of the fumes and residents reported some staff were wearing masks. She did not recall any resident room</p>	F 490	<p>4. The Regional Director of Operations will monitor any renovation as well as the Administrator's oversight within the facility twice per month for at least three (3) months. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Dietary Services Manager, Maintenance Director, Social Services Director and Activity Director with the Medical Director attending at least quarterly.</p>		

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F 490	Continued From page 37 doors being shut. The facility additionally failed to ensure Life Safety Code deficient practice was not repeated. Deficient practice was identified at K-25, 29, 38, 47, 62, 66, 72 73 and 147, which were also identified on the standard survey conducted on 06/12/13.	F 490			

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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 HEWTON AVE BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1962.</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 1962, with 21 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1962 and upgraded in 2010.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Natural Gas.</p> <p>An Abbreviated Life Safety Code Survey investigating #KY 21330 was initiated on 02/18/14 with a Standard Life Safety Code Survey. Both surveys were concluded on 02/20/14. Bowling Green Nursing and Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The complaint was found to be substantiated with deficiencies cited. The facility is certified for sixty-six (66) beds with a census of fifty-seven</p>		<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 Title 18, 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>		

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

David W. T. Adm

TITLE

Administrator

(X6) DATE

4-17-14

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2014
NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
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K 000	Continued From page 1 (57) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at a Scope and Severity of an "F". Repeat Deficiencies: The following are repeat deficiencies from the standard survey conducted on 06/12/13: K-25, 29, 38, 47, 62, 66, 69, 72, 73, and 147.	K 000			
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	<u>K 018</u>	K 018 1. Doors for rooms #1, 7, 28 and #4 have been ordered through as one hour fire-rated doors to resist the passage of smoke. Doors will be installed by on 3/28/14 2. An audit of all doors to resist the passage of smoke was conducted throughout the facility completed on 3/14/14 to validate NFPA standards. The result of all doors on indicated the rooms that have been ordered. 3. Regional Facilities Director will educate Maintenance Director and Administrator to enforce NFPA standards by 3/28/14	3/31/14	

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

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

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K 018	Continued From page 4 automatic sprinkler system in accordance with NFPA standards.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The findings include: Observations, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed the smoke barrier extending above the ceiling located in the A-Hall by room #11 did not extend to the roof sheathing.	K 025	1. The smoke barrier above room #11 has been extended to the roof sheathing. The work was completed on 3/14/14 On B-Hall by room #35, the smoke partitions will be sealed with approved sealant by 3/28/14. 2. The attic was audit for any deficiencies and none was found on 3/14/14. The attic is up to NFPA standards. 3. All future work in the attic by the Maintenance Director or outside contractor will be required to seal all penetrations to the smoke barrier immediately following the penetrations with the appropriate rated sealant. The Regional Facilities Director will educate Maintenance Director on proper sealant for smoke barriers according to NFPA standards by 3/28/14 4. Audits will be conducted monthly or when construction is taken place. The Director of Maintenance or Administrator will report any deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. . The Quality	3/31/14

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

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