STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 25 faucet off using the wrist so the hands were not contaminated. Interview with the Director of Nursing, on 01/26/12 at 3:00 PM, revealed all staff members were trained to use a paper towel to turn off water faucets to prevent contamination of the hands after washing them.	F 441		
	6. Observation of a skin assessment for Resident #6, on 01/25/12 at 3:50 PM through 4:20 PM revealed Licensed Practical Nurse (LPN) #4 provided a skin assessment with the assistance of Certified Nurse Aide (CNA) #3. LPN #4 changed her gloves five (5) times through out the skin assessment without washing her hands between glove changes. LPN #4 changed the G-Tube dressing on the resident's left abdomen and did not provide hand washing with the glove change. Interview, with CNA #3 on 01/26/12 at 7:30 PM and LPN #4 on 01/26/12 at 8:05 PM revealed they were trained to complete handwashing between glove changes. They both reported they were taught to wash their hands between every glove change and that gloves do not replace hand hygiene.			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing	F 463		

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F 463	Continued From page 26 facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a fully functional emergency call light system for one (1) of the seven (7) bathrooms on the West Hall. The findings include: The facility did not provide a policy for the emergency call light system. Observation of the shared bathroom for room 335 and 337, on initial tour 01/24/12 at 9:35 AM, revealed the emergency call light switch on the wall next to the toilet did not have an attached pull cord. Interview with Resident #8, on 01/26/12 at 4:45 PM, revealed both of the residents in room 335 use the bathroom, usually independently. The resident revealed he/she had not noticed the pull cord was missing, but expressed concern as to how they would get help if they were too fall. Interview with the Maintenance Director, on 01/26/12 at 3:35 PM, revealed he was responsible to ensure the pull cords are in place on the emergency call system. The Maintenance Director revealed a potential for the nursing staff to not be made aware if a resident was to fall while in the bathroom. Interview with the West Unit Manager, on	F 463	F463 The pull cord for the emergency call light switch on the wall next to the toilet for Rooms #335 and #337 was installed by the Maintenance Director on 01-27-2012. An audit by the Maintenance Director of all resident call lights will be conducted by 02-29-2012 to assure all are functioning including a pull cord in the bathroom. Any identified concerns will be immediately corrected. The Maintenance Director will be re-educated by the Administrator related to monthly audit for validation of a functioning call system including call cord. This education will be completed by 02-29-2012. The Maintenance Director or Maintenance Assistant will inspect all residents rooms weekly for two (2) weeks to assure all call lights are functioning and a call cord is in place followed by monthly audits for three (3) months. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance date: 03-07-2012	03-07-2012

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F 463	Continued From page 27 01/26/12 at 5:05 PM, revealed not having emergency light pull cords could create a problem due to the inability to hear the residents yelling for help while in the bathroom. The Unit Manager revealed everyone was responsible to ensure light cords are accessible and report any area that need repair. Interview with the Director of Nursing, on 01/26/12 at 5:45 PM, revealed not having a fully functional emergency call light system in the bathrooms was a definite safety issue. The DON revealed the facility has a caring partners program where the assigned staff person was to look in each room for areas of concern. However, they have not been checking the bathroom for pull cords on the emergency light.	F 463		

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	186087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1969, 1992 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V (111) SMOKE COMPARTMENTS: Seven (7) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is propane. A standard Life Safety Code survey was conducted on 01/25/12. Bon Harbor Nursing and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred thirty two (132) beds with a census of one hundred twenty two (122) 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	K 000	Submission of this plan of correction is not a legal admission that a 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 ten (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 time frame 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Chris Malvern | TITLE: X NHA | (X6) DATE: X 02-24-12

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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K 000	Continued From page 1 Fire) Deficiencies were cited with the highest deficiency identified at " F " level.	K 000		
K 018 SS=D	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 1¾ 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. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in corridors were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred	K 018	K018 The wooden gates to room 105 and room 461 were removed on 01-27-2012. An audit of all facility rooms was conducted by the Maintenance Director and no other wooden gates were found on 01-27-2012. The Maintenance Director was re-educated by the Administrator that no wooden gates can be hung at resident room doors on 02-29-2012. The Maintenance Director will audit all resident room doors for wooden gates monthly for three (3) months to assure there no wooden gates have been hung. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance Date: 03-07-2012	03-07-2012

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K 018	Continued From page 2 thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The findings include: Observation, on 01/25/12 at 3:49 PM, with the Maintenance Director revealed the facility had installed hinged wooden gates on resident room #105, and #461 to prevent wandering residents from entering these rooms. Further observation revealed the gates when closed impede access to the room door to enable closure during a fire. Interview, on 01/25/12 at 3:49 PM, with the Maintenance Director revealed the facility had placed the gates on the resident room doorframes due to residents wandering into other resident rooms. Reference: NFPA 101 (2000 Edition). 19.3.6.3 Corridor Doors. 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 13/4-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,	K 018		

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K 018	Continued From page 3 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 automatic sprinkler system in accordance with 19.3.5.2. 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: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	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	K 025	K025 The identified smoke barrier penetrations will be repaired using fire caulking by the Maintenance Director by 03-05-2012. An audit of the smoke barriers will be completed by 02-29-2012 to ensure there are no penetrations and any identified concerns will be immediately corrected.	

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K 025	Continued From page 4 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 seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The findings include: Observation, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the smoke partitions extending above the ceiling in all of the smoke barriers to be penetrated by pipes and wires. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Further observation revealed the Fire Wall next to the Administrators Office was not continuous to the roof above. The fire wall stopped approximately two (2) feet down from the ridge of the roof, and was about five (5) feet wide at the base of the penetration.	K 025	The Maintenance Director will be re-educated by the Administrator related to the requirement for smoke barriers per NFPA 101. This re-education will be completed by 2-29-2012. The Maintenance Director will audit all smoke barriers monthly for three (3) months to assure there are no penetrations to the smoke barriers. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance date: 03-07-2012	03-07-2012

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K 025	Continued From page 5 Interview, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware of the penetrations, or how the fire wall had been in this condition. Reference: NFPA 101 (2000 Edition). 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 between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. Reference: NFPA 101 (2000 Edition). 8.2.3.2.3.1	K 025		

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K 025	Continued From page 6 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protective ' s shall be as follows: (3) 1/2-hour fire barrier - 20-minute fire protection rating (1) 2-hour fire barrier - 11/2-hour fire protection rating (2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42 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.	K 025		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are	K 027	K027 The Maintenance Director adjusted the closer and trimmed the kickplate on the cross-corridor fire doors located next to the Administrator's office on 01-27-2012. An audit of all fire doors was conducted on 01-27-2012 by the Maintenance Director with no concerns identified.	

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K 027	Continued From page 7 not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross -corridor doors located in a smoke barrier would resist the passage of smoke. These doors must close all the way and be smoke tight to help prevent smoke from reaching other parts of the building in the event of an emergency. The deficiency had the potential to affect the two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the days of the survey. The findings include: Observation, on 01/25/12 at 4:00 PM, with the Maintenance Director revealed the cross-corridor fire doors located next to the Administrators Office, would not close completely when tested, leaving a gap of approximately one-quarter of an inch between the pair of doors and would not resist the passage of smoke. Interview, on 01/25/12 at 4:00 PM, with the Maintenance Director revealed they were unaware the doors would not close all the way leaving a gap between the doors in the closed position and acknowledged the doors would not resist the passage of smoke in the event of an emergency.	K 027	The Maintenance Director will be re-educated by the Administrator related to the requirement for corridor doors per NFPA 101. This re-education will be completed by 2-29-2012. The Maintenance Director will audit all corridor doors monthly for three (3) months to assure they close properly. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance date: 03-07-2012	03-07-2012

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K 027	Continued From page 8 Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey.	K 029	K029 A fire rated door with a self closing device will be installed by 3-6-2012. An audit of all facility rooms was conducted on 01-27-2012 by the Maintenance Director and no other non-fire rated doors without self closing devices were found. The Maintenance Director will be re-educated by the Administrator related to the requirement for Protection from Hazards and Hazardous Areas per NFPA 101. This re-education will be completed by 02-29-2012. The Maintenance Director will audit all facility room doors for non-fire rated doors monthly for three (3) months to assure there none are present. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 9 The findings include: Observation, on 01/25/12 at 1:07 PM, with the Maintenance Director revealed the door between the clean linen room and the laundry room to be unrated and did not have a self closing device. Interview, on 01/25/12 at 1:07 PM, with the Maintenance Director revealed they were not aware the door was unrated and needed a self closing device. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms	K 029	Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance date: 03-07-2012	03-07-2012

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DIVISION OF HEALTHCARE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 10 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress in accordance with NFPA standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey.	K 038	K038 The identified fire exit will have a durable surface access installed to a public way by 02-29-2012. An audit of all facility fire exits was conducted on 01-27-2012 by the Maintenance Director and no other non-durable surfaces were found. The Maintenance Director will be re-educated by the Administrator related to the requirement that all fire exits have a durable surface to a public way. This re-education will be completed by 02-29-2012. The Maintenance Director will audit all fire exits to ensure all have a durable surface monthly for three (3) months. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 11 The findings include: Observation, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the exit to the resident smoking area, and the Skilled B exit, did not have a durable surface to a public way. Interview, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was aware the exits needed a durable surface to a public way, but cannot fix something that big without Corporate approval. Exits must have a durable surface to the public way to support wheelchairs, beds, equipment, etc., in case of an emergency situation.	K 038	meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance date: 03-07-2012	03-07-2012
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	K056 Sprinklers will be installed on the two (2) porches located outside the exits in the skilled wing, the one (1) outside the exit door to the resident smoking area and to the one (1) located outside the Therapy exit. The roof to the employee smoking area was removed on 02-08-2012. An audit of all facility exterior roofs was conducted on 01-27-2012 by the Maintenance Director and no other without sprinkler systems were found. The Maintenance Director will be re-educated by the Administrator related to the requirement that sprinklers shall be installed under exterior roofs or canopies exceeding four feet (1.2m) in width per NFPA 13. This re-education will be completed by 02-29-2012.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The findings include: Observation, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed five (5) porches to extend out four (4) foot or greater, made of combustible materials, and were not sprinkler protected. Two (2) porches are located outside the exits in the skilled wing, one (1) is located outside the exit door to the smoking area, one (1) is located at the employee smoking area, and one (1) is located outside the Therapy exit. Interview, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed they were not aware the porches needed to be sprinkler protected. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width.	K 056	The Maintenance Director will audit all exterior roofs and canopies to ensure all have the proper sprinkler system monthly for three (3) months. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance date: 03-07-2012	03-07-2012

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DIVISION OF HEALTH CARE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 13 Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The findings include: Observation, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed paint on the sprinkler heads located in the North Med Room. Further observation revealed the facility had recalled STAR sprinkler heads that had been brought to their attention by the sprinkler contractor on one of the quarterly inspection reports. The facility failed to produce evidence that the recalled sprinkler heads had been checked or replaced.	K 062	K062 The sprinkler heads in the North Med Room will be replaced. The sprinkler heads in the facility are 1992 Star Sprinkler heads and the ones that were recalled were Star Sprinkler heads from 1961 to 1976. that were recalled are not the sprinklers in the facility. An audit of all facility sprinkler heads was conducted on 01-27-2012 by the Maintenance Director and no concerns noted. The Maintenance Director will be re-educated by the Administrator related to the requirement that sprinklers This re-education will be completed by 02-29-2012. The Maintenance Director will audit all sprinkler heads monthly for three (3) months to assure they are free of corrosion, foreign materials, paint and physical damage. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The	

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SYSTEM OF CARE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 14 Interview, on 01/25/12 between 1:00 AM and 5:00 PM, with the Maintenance Director revealed they were not aware of the paint on the med room sprinkler heads. Further interview revealed they were aware of the recall on the STAR sprinkler heads but did not think they had any of the recalled heads. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:	K 062	Medical Director will attend at least quarterly.	03-07-2012

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DIVISION OF HEALTH CARE FACILITIES SURVEYS

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 15 (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K 066	K066 The unapproved ashtrays were removed and metal ashtrays with self closing lids were placed in the smoking area by the Maintenance Director on 02-09-2012. An audit of all facility smoking areas was conducted on 01-27-2012 by the Maintenance Director and no concerns noted. The Maintenance Director will be re-educated by the Administrator related to the smoking regulations listed in NFPA 101. This re-education will be completed by 2-29-2012.	

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DIVISION OF

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 16 (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect residents, staff and visitors. The facility is licensed for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The findings include: Observation, on 01/25/12 at 3:24 PM, with the Maintenance Director revealed the ashtrays located at the designated smoking areas, were not of the unapproved type. They did not have a metal container with a self-closing lid to dump ashtrays. Interview, on 01/25/12 at 3:24 PM, with the Maintenance Director revealed the ashtrays would be removed and an ashtray of the approved type would be provided. Reference: NFPA Standard 101 (2000 Edition).	K 066	The Maintenance Director will audit all smoking areas monthly for three (3) months to assure no ashtrays are present that do not meet the regulation. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance date: 03-07-2012	03-07-2012

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DIVISION OF LICENSURE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 17 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	K130	
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. This deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one ~~hundred thirty two (132) beds, with a census of one hundred twenty two (122) on the day of the~~ survey. The findings include: Observation, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed an unapproved lock (slide bolt type) was installed on the egress side of most bathroom doors throughout the facility in resident rooms. Interview, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed they were told to install the locks by the former Administrator.	K 130	The unapproved locks were removed on 02-02-2012. An audit of all facility bathroom locks was conducted on 02-02-2012 by the Maintenance Director and no concerns noted. The Maintenance Director will be re-educated by the Administrator that doors within a required means of egress shall not be equipped with a latch or lock that requires the us of a tool or key from the egress side listed in NFPA 101. This re-education will be completed by 2-29-2012. The Maintenance Director will audit all resident ~~bathroom doors monthly for three (3) months to~~ assure there are no unapproved locks. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance date: 03-07-2012	03-07-2012

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 18 Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	K 147	K147 The identified power strips with medical equipment attached and extension cords were removed on 02-17-2012 by the Maintenance Director. An audit of all facility rooms including offices will be conducted by 02-29-2012 to identify any concerns with power strips used for medical equipment or extension cords. Any identified concerns will be immediately corrected. The Maintenance Director will be re-educated by the Administrator related to the requirement that extension cords not be used and that power strips may not be used for medical equipment. This re-education will be completed by 2-29-2012. The Maintenance Director will audit all facility rooms monthly for three (3) months to assure that no extension cords are used for medical equipment. The results of these audits will be reviewed with the Quality Assurance Committee.	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The findings include: Observation, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed: 1) Open electrical junction boxes were found throughout the attic spaces. 2) A bed was plugged into a power strip located in room #108. 3) An oxygen concentrator was plugged into a power strip located in room #104. 4) A feeding machine was plugged into a power strip located in room #103.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 19 5) A bed and an oxygen concentrator were plugged into a power strip located in room #101. 6) A power strip was plugged into an extension cord located in the Administrators Office. 7) A refrigerator was plugged into a power strip located in the Business Office. 8) A bed was plugged into a power strip located in room #445. 9) A refrigerator was plugged into a power strip located in room #454. 10) A bed, suction pump, and a feeding machine were plugged into a power strip located in room #453. 11) An oxygen concentrator was plugged into a power strip located in room #451. 12) An oxygen concentrator, and a refrigerator were plugged into a power strip located in room #342. 13) Two (2) air mattress pumps, a feeding machine, an oxygen concentrator, and two (2) beds were plugged into power strips located in room #343. This room also had an extension cord in use. 14) An oxygen concentrator, a bed, and a refrigerator were plugged into a power strip located in room #340. 15) A bed was plugged into a power strip located in room #336. Interview, on 01/25/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed they were not aware of the misuse of power strips and extension cords, or the open junction boxes in the attic. The facility was cited for open junction boxes in a	K 147	on a monthly basis for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Compliance date: 03-07-2012	03-07-2012

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DIVISION OF HEALTH CARE FACILITIES SURVEYS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 147	Continued From page 20 2011 survey. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		
	110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. Reference: NFPA 70 (1999 edition) 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.			

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DHHS OFFICE OF HEALTH CARE FACILITIES AND SERVICES

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

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