

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

PRINTED: 01/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/28/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance on 01/21/16, as alleged.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X8) DATE	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185089	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 1/28/2016	Y3
NAME OF FACILITY SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0279	Correction	ID Prefix F0281	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(l)	Completed
LSC	01/21/2016	LSC	01/21/2016	LSC	01/21/2016
ID Prefix F0282	Correction	ID Prefix F0315	Correction	ID Prefix F0323	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(d)	Completed	Reg. # 483.25(h)	Completed
LSC	01/21/2016	LSC	01/21/2016	LSC	01/21/2016
ID Prefix F0328	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.25(k)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	01/21/2016	LSC	01/21/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) <i>DH</i>	DATE <i>2/2/16</i>	SIGNATURE OF SURVEYOR <i>Deborah A. Henderson, NCF, DR</i>	DATE <i>01/29/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/18/2015

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 850 HIGH ST. BOWLING GREEN, KY 42101
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F 000	INITIAL COMMENTS	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 241 SS=D	<p>A Recertification Survey and an Abbreviated Survey investigating Complaint #KY24120 was conducted on 12/15/16 through 12/18/15 with deficiencies cited at the highest Scope and Severity of a "D". Complaint #KY24120 was unsubstantiated with no deficiencies.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</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 maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for one (1) of twenty-four (24) sampled residents (Resident #15).</p> <p>Staff failed to provide privacy by closing the shades, pulling the curtain or shutting the door while providing Gastrostomy Tube (G-Tube) site care to Resident #15.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Rights", not dated, revealed employees shall treat all residents with kindness, respect and dignity. Further review under Guideline number one (1)</p>	F 241	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.</i></p> <p>F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <ol style="list-style-type: none"> Resident #15 no longer resides in the facility. RN #1 was re-educated by the Staff Development Coordinator on 12/17/2015, on providing privacy and dignity for all residents with emphasis on closing doors, pulling privacy curtains and window blinds when providing care. Resident interviews concerning respect, dignity and privacy have been conducted by Administrative Staff in AbaQIS and completed by 1/20/2016. No complaints or concerns noted during interviews or in resident council. All nursing staff and therapy were re-educated on providing respect, dignity and privacy to all residents at all times by the Staff Development Coordinator. Education was completed by 1/20/2016. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 1/27/2016

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 650 HIGH ST. BOWLING GREEN, KY 42101
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F 241	<p>Continued From page 1</p> <p>revealed "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to privacy and confidentiality."</p> <p>Record review revealed the facility admitted Resident #15 on 10/02/15 with diagnoses which included Cerebrovascular Accident, Deafness, Congestive Heart Failure and Diabetes Mellitus. Review of the Admission Minimum Data Set (MDS) Assessment, dated 10/09/15, revealed Resident #15 was unable to complete a Brief Interview for Mental Status (BIMS) but the facility assessed the resident as he/she was rarely or never understood which indicated he/she was not interviewable.</p> <p>Observation, on 12/17/15 at 2:45 PM, revealed Registered Nurse (RN) #1 provided G-Tube site care for Resident #15; however, RN #1 failed to close the window-shade, pull the privacy curtain or shut the door to the room prior to raising the resident's shirt up and providing G-Tube site care. Further observation revealed he/she had no roommate; however, he/she could be seen from both the hall and from the window.</p> <p>Interview with RN #1, on 12/17/15 at 3:00 PM, revealed he forgot to provide privacy for Resident #15 prior to starting G-Tube site care. RN #1 stated he normally pulls the privacy curtain, shuts the door and pulls the window-shade down to provide the resident privacy. He said other residents, staff and visitors could have potentially seen Resident #15 exposed during care due to the window-shade, privacy curtain and door being left opened.</p> <p>Interview with Resident #15's family member, on</p>	F 241	<p>(cont.)</p> <p>4. Observations will be conducted on 5 residents by Unit Managers/ADONs weekly X 4 weeks, then monthly X 3 months to ensure respect, privacy and dignity are maintained for all residents at all times. The results of the observations will be taken to QAPI for with results presented in QAPI for tracking and trending and further recommendations. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director or ARNP, NHA, DON, ADONs, Unit Manager, QA (Quality Assurance) Nurse, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators, Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises.</p> <p>5. Completion 1/21/2016.</p>	1/21/16

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F 241	Continued From page 2 12/17/15 at 3:10 PM, revealed she expected staff to provide privacy when providing care to the resident to ensure the resident was not exposed to other residents and visitors. She stated Resident #15 had always been very prideful and would not be all right with not having privacy for procedures and being exposed for others to see him/her. Interview with the Unit Manager (UM), on 12/17/15 at 4:09 PM, revealed she expected staff to provide all residents privacy during any type of care or procedure and that it was not appropriate for a resident to be exposed and privacy not being provided. Interview with the Director of Nursing (DON), on 12/18/15 at 2:50 PM, revealed she expected staff to always provide privacy for all residents during any type of procedure or care being provided.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		

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F 279	<p>Continued From page 3</p> <p>§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to develop a Comprehensive Care Plan for one (1) of twenty-four (24) sampled residents related to gastrostomy site care (Resident #15). Resident #15 was admitted to the facility on 10/02/15 with a Gastrostomy Tube (G-tube); however, no care plan was developed to address the care of the resident's G-tube site.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans-Comprehensive", dated 08/01/15, revealed "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." Under guideline number one (1) it states: "The nurse/interdisciplinary team, in coordination with the resident, his/her family or responsible party develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to maintain. Under guideline number three (3) it states: each resident's comprehensive care plan is designed to identify the professional services that are responsible for each element of care</p>	F 279	<p>F 279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <ol style="list-style-type: none"> 1. The Quality Assurance Nurse assessed resident #15 and developed a care plan for g-tube site care on 12/30/2015. Resident #15 no longer resides in the facility. 2. All residents with g-tubes were reviewed by the Quality Assurance Nurse on 12/30/2015 and each one had been assessed and a care plan was in place for the g-tube care. 3. Licensed staff have been re-educated by the Staff Development Coordinator on proper assessment of residents and proper care planning. Education was completed by 1/20/2016. 4. All residents with g-tubes were re-assessed by the Quality Assurance Nurse on 12/30/2015 to ensure each one had proper orders, assessments and care plans in place for the care. The Quality Assurance Nurse will re-assess any new resident with a g-tube upon admission or upon the insertion of a g-tube weekly x 4 weeks, then monthly x 4 months and ongoing. Results will be taken to QAPI with any concerns with results presented in QAPI for tracking and trending and further recommendations. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director or ARNP, NHA, DON, ADONs, QA Nurse, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators, Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises. 5. Completion 1/21/2015. 	1/21/16	

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F 279	<p>Continued From page 4</p> <p>Record review revealed the facility admitted Resident #15 on 10/02/15 with diagnoses which included Cerebrovascular Accident, Deafness, Congestive Heart Failure and Diabetes Mellitus. Review of the Admission Minimum Data Set (MDS) Assessment, dated 10/09/15, revealed this resident was unable to complete a Brief Interview for Mental Status (BIMS) because he/she was rarely or never understood and this indicated he/she was not interviewable. In addition, the resident was assessed to have a tube feeding in place while at the facility.</p> <p>Review of the Comprehensive Care Plans for Resident #15, dated 10/09/15 and 10/13/15, revealed there were no identified interventions related to G-Tube site care.</p> <p>Review of Resident #15's December 2015 Treatment Administration Records (TAR) revealed there was no G-Tube site care recorded on the TAR so licensed staff would be cued to perform the care.</p> <p>Interview (Post Survey) with Licensed Practical Nurse (LPN) #5, on 12/30/15 at 10:47 AM, revealed Resident #15 should have had a care plan developed for care of the G-Tube site.</p> <p>Interview (Post Survey) with the Quality Assurance (QA) Nurse, on 12/30/15 at 11:30 AM, revealed a care plan should have been implemented on admission in regards to G-Tube site care for Resident #15.</p> <p>Interview with the facility Administrator, on 12/30/15 at 11:40 AM, revealed a care plan should have been implemented in regards to G-Tube site care for Resident #15 upon</p>	F 279			

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F 279	Continued From page 5 admission.	F 279			
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Perry and Potter Ostendorf Clinical Nursing Skills & Techniques 8th Edition, it was determined the facility failed to provide services that meet professional standards of quality for two (2) of twenty-four (24) sampled residents (Resident #7 and Resident #15). Staff failed to date and lime a wound dressing for Resident #7 and failed to provide Gastrostomy tube site care appropriately for Resident #15.</p> <p>The findings include:</p> <p>1. Review of facility standards of practice, entitled: Perry and Potter Ostendorf Clinical Nursing Skills & Techniques 8th Edition, revealed to label dressing with date dressing applied.</p> <p>Record review revealed the facility admitted Resident #7 on 03/03/15 with diagnoses, which included Diabetes Mellitus II, Sepsis, and a Stage II Pressure Ulcer. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/23/15, revealed Resident #7 was assessed as requiring extensive assistance with activities of daily living (ADLs), and to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident</p>	F 281	<p>F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>1. A.) The dressing on resident #7 was changed and dated on 12/17/2015 by the Wound Care Nurse and the licensed nurse who had previously changed the dressing and did not date the dressing, was given a coach and counselling by the Director of Nursing on 12/21/2015. B.) The RN #1 who provided improper g-tube sight care to resident #15 was given a coaching and counselling by the Director of Nursing on 12/21/2015.</p> <p>2. A.) Wound Care Nurse checked all the wound dressings for dates and initials for the next week and completed observations on licensed nurses providing proper g-tube care. B.) The RN completed competency on proper g-tube care by the Staff Development Coordinator on 12/17/2015 and again on 1/8/2016. All residents with g-tubes were reviewed by the Quality Assurance Nurse on 12/30/2015 and each one had been assessed, a care plan was in place, and an order had been received and entered on the TAR for the g-tube care. Competency Check offs on g-tube site care was completed on all licensed nursing staff to ensure each nurse could perform the task correctly. This was completed on 1/20/2016.</p> <p>3. All licensed staff were re-educated by the Staff Development Coordinator to always date and initial wound dressings and the proper way to perform g-tube care. Education was completed by 1/20/2016.</p>		

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F 281	<p>Continued From page 6 was interviewable.</p> <p>Observation, on 12/17/15 at 3:35 PM, revealed the Wound Care Nurse completed a dressing change to Resident #7's pressure ulcer on his/her sacrum. There was no date, time or initialing on the dressing removed from the resident. The Wound Care Nurse stated the dressing should be dated, timed, and initialed per facility policy.</p> <p>Interview with Unit Manager (UM) #1, on 12/17/15 at 1:56 PM, and interviews on 12/18/15 with the Director of Nursing (DON) at 11:20 AM, and the Administrator at 9:45 AM, revealed they expected dressings to be initialed and dated when applied.</p> <p>2. Further review of facility's standards of practice, Perry-Potter-Ostendorf Clinical Nursing Skills and Techniques Eighth (8th) Edition, revealed under 'Care of a Gastrostomy or Jejunostomy Tube, on page 794, staff should perform hand hygiene and apply clean gloves; remove old dressing and fold dressing with drainage contained inside, then remove gloves inside out over dressing and discard; assess exit site; clean skin around site with warm water and mild soap or saline using four (4) by four (4) gauze and if drainage is present apply clean gloves; dry site completely; if dressing is ordered, place a drain-gauze dressing over the disc; secure dressing with tape; place date, time and initials on new dressing; and remove gloves and dispose of supplies in appropriate receptacle and perform hand hygiene.</p> <p>Record review revealed the facility admitted Resident #15 on 10/02/15 with diagnoses which included Cerebrovascular Accident, Deafness, Congestive Heart Failure and Diabetes Mellitus.</p>	F 281	<p>(chit)</p> <p>4. The Unit Managers/ADONs and Staff Development Coordinators will observe 5 residents with wound care dressings and 5 residents requiring g-tube care weekly x 4 weeks, monthly x 4 months and the results of observations will be reported to the QAPI committee for tracking and trending and further recommendations. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director or ARNP, NHA, DON, ADONs, QA Nurse, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators., Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises.</p> <p>5. Completion 1/21/2016.</p>	1/21/16	

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
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F 281	<p>Continued From page 7</p> <p>Review of the Admission MDS Assessment, dated 10/09/15, revealed Resident #15 was unable to complete a BIMS because he/she was rarely or never understood and this indicated he/she was not interviewable. In addition, the resident was assessed to have a tube feeding in place while at the facility.</p> <p>Observation, on 12/17/15 at 2:45 PM, revealed Registered Nurse (RN) #1 with gloved hands wheeled Resident #15 into his/her room and arranged supplies of a drainage-gauze, tape, a towel and a wash cloth and placed them on the bedside table. RN #1 raised Resident #15's shirt to expose the G-Tube site and then removed the old dressing, which had visible brownish drainage present, and threw it in the trash can. He then took his gloved right index finger and removed a brownish crust-like material from Resident #15's G-Tube site. He grabbed the washcloth from the bedside table, wet the washcloth at the sink, and applied soap to the washcloth. RN #1 returned to Resident #15 and began to wash Resident #15's G-Tube site with the wet, soapy washcloth. RN #1 then took the soiled washcloth back to the sink, rinsed it out, applied soap to it again, returned to Resident #15, and washed Resident #15's G-Tube site again with the same washcloth. He then placed the soiled washcloth in Resident #15's sink, picked up the towel, dried Resident #15's G-Tube site, and then placed the towel in the sink. RN #1 opened the drainage-gauze package, removed the gauze and placed the gauze over the G-Tube site and secured it with tape, then initialed and dated the dressing. He then lowered Resident #15's shirt and stated he was complete with the G-Tube site care. RN #1 failed to wash his hands and apply clean gloves prior to the procedure, used the same washcloth</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 850 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 8 to clean the G-tube site twice, and failed to change gloves after removing the old dressing, and after cleaning g-tube site, and applying clean dressing per the standards of practice. Interview with RN #1, on 12/17/15 at 3:00 PM, revealed he forgot to change gloves but in hindsight should have changed gloves prior to starting G-Tube site care, after removing the old dressing, after removing brownish crust-like material from the G-Tube site and prior to placing the new dressing to Resident #15's G-Tube site. RN #1 stated he should have had more supplies in place, to include a basin with warm water and additional wash cloths and he should not have used the same soiled wash cloth for a second time to cleanse Resident #15's G-Tube site because the wash cloth was dirty from the first cleansing. Interview with the UM, on 12/17/15 at 4:09 PM, revealed she expected staff to provide proper G-Tube site care per professional standards. Interview with the DON, on 12/18/15 at 2:50 PM, revealed she expected staff to provide proper G-Tube site care per standards of practice and Licensed Staff should be aware of the facility policy and procedures related to G-Tube site care.	F 281			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 560 HIGH ST. BOWLING GREEN, KY 42101		
(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 282	Continued From page 9 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 ensure staff provided services in accordance with the written plan of care for one (1) of twenty-four (24) sampled residents (Resident #8). The facility failed to follow Resident #8's care plan intervention of providing catheter care per facility policy. The findings include: Review of facility's policy titled, "Care Plans-Comprehensive", dated 08/01/16, revealed "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." Under guideline number one (1) it states: The nurse/Interdisciplinary team, in coordination with the resident, his/her family or responsible party develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to maintain. Under guideline number three (3), it states each resident's comprehensive care plan is designed to identify the professional services that are responsible for each element of care. Under guideline number eight (8), it states care plans are revised as information about the resident and the resident's condition change. Review of the facility policy titled, "Catheterization Care", last reviewed 08/01/15, revealed staff should organize equipment for perineal care; wash and dry hands thoroughly-put on gloves.	F 282	F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. The facility provides care in accordance with the residents' plan of care. RN # 2 was education by the SDC on providing proper Foley catheter care and competency completed on 1/13/2016. 2. The Staff Development Coordinator observed Foley catheter care on all residents with a Foley Catheter and care was provided as care planned. This was completed by 1/20/2016. All residents with Foley catheters were assessed for proper orders and complete care plans. 3. All licensed staff were re-educated by the Staff Development Coordinator on following the residents' plan of care and proper Foley catheter care this was completed on 1/20/2016. 4. Care plans and following the plan of care will be audited and observed on 5 residents with Foley Catheters by the Unit Managers/ADONs weekly x 4 weeks and then monthly x 4 months with results presented in QAPI for tracking and trending and further recommendations. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director or ARNP, NHA, DON, ADONS, QA Nurse, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators., Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises. 5. Completion 1/21/2016	1/21/16	

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(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 282	<p>Continued From page 10</p> <p>with female residents: use non-dominant hand to gently separate labia fully to expose urethral meatus and catheter and maintain position of hand throughout procedure; grasp catheter with two fingers to stabilize it; assess urethral meatus and surrounding tissue for inflammation, swelling, discharge or tissue trauma; provide perineal hygiene using mild soap and warm water; use a clean wash cloth and clean catheter-starting close to urinary meatus clean catheter in circular motion along its length for about four (4) inches moving away from the body; reapply catheter securement device and allow slack in catheter so movement does not create tension on it.</p> <p>Record review revealed the facility admitted Resident #8 on 12/11/15 with diagnoses, which included Urinary Tract Infection and Renal Insufficiency.</p> <p>Review of Resident #8's Interim Admission Care Plan, dated 12/10/15, revealed staff was to provide catheter care per policy.</p> <p>Observation of Registered Nurse (RN) #2 providing urinary indwelling catheter care for Resident #8, on 12/17/15 at 1:10 PM, revealed RN #2 placed gloves on prior to obtaining a wash cloth, soap and a basin with warm water and raising Resident #8's bed up. The RN failed to wash her hands and apply gloves after she had gathered her supplies and positioning the resident per resident care plan. She then informed the resident of needing to provide catheter care, and removed the resident's covers and lower extremity clothing. She removed the catheter securement device, which was on the resident's upper right thigh. Further observation revealed RN #2 then grabbed a wet soapy wash</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 668 HIGH ST. BOWLING GREEN, KY 42101
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F 282	<p>Continued From page 11</p> <p>cloth and cleansed the resident's vaginal area without changing gloves and separating the labia to expose the urethral meatus and catheter to assess the urethral meatus and surrounding tissue for inflammation, swelling, discharge or tissue trauma per resident care plan. RN #2 then started to wash the resident's catheter with the same washcloth instead of a clean washcloth. Resident #8 refused to let RN #2 complete catheter care after RN #2 started cleansing the catheter.</p> <p>Interview with RN #2, on 12/17/15 at 1:30 PM, revealed she was expected to know the resident's care plans and she should have followed it.</p> <p>Interview with the Unit Manager (UM), on 12/17/15 at 4:09 PM, revealed she expected staff to be familiar with the residents' care plans and to follow them.</p> <p>Interview with Director of Nursing (DON), on 12/18/15 at 2:50 PM, revealed she expected staff to know and follow the residents' care plans.</p>	F 282		
F 315 SS=O	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p>	F 315		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	
(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 315	Continued From page 12 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 ensure appropriate treatment and services were provided to prevent urinary tract infections for two (2) of twenty-four (24) sampled residents (Resident #8 and #15). Staff failed to provide indwelling catheter care per the facility's policy/resident's care plan for Resident #8 and failed to ensure indwelling catheter tubing was off the floor for Residents #8 and #15, to prevent Urinary Tract Infections. The findings include: Review of the facility policy titled, "Catheterization Care", last reviewed 06/01/15, revealed staff are to organize equipment for perineal care; wash and dry hands thoroughly-put on gloves, with female residents: use non-dominant hand to gently separate labia fully to expose urethral meatus and catheter and maintain position of hand throughout procedure; grasp catheter with two fingers to stabilize it; assess urethral meatus and surrounding tissue for inflammation, swelling, discharge or tissue trauma; provide perineal hygiene using mild soap and warm water; use a clean wash cloth and clean catheter-starting close to urinary meatus clean catheter in circular motion along its length for about four (4) inches moving away from the body; reapply catheter securement device and allow slack in catheter so movement does not create tension on it. Record review revealed the facility admitted Resident #8 on 12/11/15 with diagnoses, which	F 315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 1. The catheter tubing for resident #8 and Resident #15 were removed from the floor by licensed nurse on 12/17/2015. The RN #2 received a counselling on proper catheter care. Neither incident resulted in a urinary tract infection; however both had urinary tract infections when admitted to the facility. 2. All Foley catheter tubing is being monitored by the Unit Managers daily x 7 days to ensure they are not touching the floor. RN #2 completed a competency on Foley catheter care by the Staff Development Coordinator on 1/13/2016. 3. All nursing staff and therapy received re-education by the Staff Development Coordinator on proper placement of Foley catheter tubing. All licensed staff were re-educated on proper Foley catheter care by the Staff Development Coordinator. All education was completed by 1/20/2016. 4. 5 Residents with Foley catheters will be monitored daily x 14 days by the Unit Managers/ADONs and then weekly x 4 weeks and monthly x 4 months to ensure tubing is properly placed. All licensed staff will be observed providing Foley catheter care and checked off by the SDC. All results will be taken to QAPI for tracking and trending and further recommendations. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director or ARNP, NHA, DON, ADONs, QA Nurse, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators., Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises. 5. Completion 1/21/2016.	1/21/16

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 850 HIGH ST. BOWLING GREEN, KY 42101
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F 315	<p>Continued From page 13</p> <p>Included Urinary Tract Infection and Renal Insufficiency.</p> <p>Review of Resident #8's Interim Admission Care Plan, dated 12/10/15, revealed staff was to provide catheter care per policy.</p> <p>Observation of Registered Nurse (RN) #2 providing urinary indwelling catheter care for Resident #8, on 12/17/15 at 1:10 PM, revealed RN #2 placed gloves on prior to obtaining a wash cloth, soap and a basin with warm water and raising Resident #8's bed up. RN #1 failed to of washing her hands and applying gloves after she had gathered her supplies and positioning the resident per facility policy. She then informed the resident of needing to provide catheter care, and removed the resident's covers and lower extremity clothing. She removed the catheter securement device, which was on the resident's upper right thigh. Further observation revealed RN #2 then grabbed a wet soapy wash cloth and cleansed the resident's vaginal area without changing gloves and separating the labia to expose the urethral meatus and catheter to assess the urethral meatus and surrounding tissue for inflammation, swelling, discharge or tissue trauma per facility policy. RN #2 then started to wash the resident's catheter with the same washcloth instead of a clean washcloth per policy. Resident #8 refused to let RN #2 complete catheter care after RN #2 started cleansing the catheter.</p> <p>Interview with RN #2, on 12/17/15 at 1:30 PM, revealed she would expect to have placed clean gloves on prior to starting catheter care but forgot to do so at the time. She further stated she failed to provide appropriate catheter care as she was</p>	F 315		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(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 315	<p>Continued From page 14</p> <p>unable to position Resident #8 appropriately alone and needed assistance from staff prior to starting catheter care. She also stated she should have followed the policy in regards to urinary catheter care, which would have included separating the resident's labia fully to expose the urethral meatus and catheter for inspection and thorough cleansing.</p> <p>Interview with the Unit Manager (UM), on 12/17/15 at 4:09 PM, revealed she expected staff to change gloves after setting residents up for catheter care and prior to starting catheter care. She also stated she expected staff to follow the facility's policy in regards to performing catheter care. She further stated not performing proper catheter care could lead to urinary tract infections.</p> <p>Interview with the Director of Nursing (DON), on 12/18/15 at 2:50 PM, revealed she expected staff to put on clean gloves prior to starting catheter care and she further expected staff to follow the facility's policy on catheter care.</p> <p>Further observation of Resident #8, on 12/15/15 at at 4:45 PM, on 12/16/15 at 9:30 AM, and on 12/17/15 at 4:25 PM, revealed his/her indwelling urinary catheter tubing to be resting on the floor.</p> <p>2. Record review revealed the facility admitted Resident #15 on 10/02/15 with diagnoses, which included Cerebrovascular Accident, Deafness, Congestive Heart Failure, and Diabetes Mellitus. Review of the Admission Minimum Data Set (MDS) Assessment, dated 10/09/15, revealed this resident was unable to complete a Brief Interview for Mental Status (BIMS) because the resident was rarely or never understood, which indicated</p>	F 315			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 650 HIGH ST. BOWLING GREEN, KY 42101		
(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 315	Continued From page 15 he/she was not interviewable. Observation of Resident #15 on 12/16/15 at 10:15 AM and 12:35 PM, and on 12/17/15 at 2:40 PM, revealed his/her indwelling urinary catheter tubing to be resting on the floor. Interview with Certified Nurse Aide (CNA) #3, on 12/17/15 at 1:35 PM, revealed he expected all residents with indwelling urinary catheters to have the catheter tubing to be off the floor due to the tubing being on the floor could cause a resident to have an infection. Interview with the UM, on 12/17/15 at 4:09 PM, revealed she expected urinary catheter tubing to be off of the floor and that by the tubing being on the floor there was a potential to cause a resident an infection. Interview with the DON, on 12/18/15 at 2:50 PM, revealed she expected all urinary catheter tubing to be off the floor as this could cause an infection.	F 315			
F 323 SS=D	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, record review,	F 323			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 560 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 16</p> <p>and facility policy review, the facility failed to ensure the resident environment was free of accident hazards as possible for one (1) of twenty-four (24) sampled residents (Resident #1). On 12/15/15, staff identified Resident #1 had a wound that the resident stated occurred while using the Continuous Passive Motion (CPM) machine; however, the facility continued to use the machine (for three treatments) without obtaining an immediate assessment by Physical Therapy (PT) to determine the cause of the wound.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Accidents and Incidents - Investigating and Reporting", updated 06/01/15, revealed guidelines include the Nurse Supervisor/Charge Nurse and/or the Department Director or Supervisor shall initiate and document investigation of the accident or incident. Data to be included in "Event Manager" (electronic incident reporting system) revealed date and time of the accident/incident, nature of the illness/injury, circumstances surrounding the accident/incident, location of the accident/incident, names of witnesses and accounts of the accident/incident, time physician was notified with instructions, family notification, condition of the injured person to include vital signs, disposition of the injured, corrective action taken, follow-up information, other pertinent data as needed, and name and title of person completing the report. The facility shall be in compliance with rules and regulations governing accidents/incidents involving a medical device, and incidents will be reported to the Administrator and/or Director of Nursing (DON). If "Event Manager" is down, document reports on paper</p>	F 323	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <ol style="list-style-type: none"> 1. Resident #1 no longer resides in the facility. 2. All incidents and accidents are reviewed thoroughly with investigations to determine the root cause of an injury. An immediate intervention is put into place to prevent any further injuries. Resident #1 said this incident never occurred again. 3. All licensed staff were re-educated by the Staff Development Coordinator to ask why 5 times to determine the root cause of any injury or accident and to put an immediate intervention into place so another accident or injury does not occur. Education completed by 1/20/2016. 4. All incidents and accidents are reviewed daily in clinical morning meetings by the Unit Managers and on weekends by the Weekend Supervisor to determine that a cause of an incident has been determined, and an immediate intervention has been put into place along with the care plan and CNA care record updated. A fall guideline binder has been placed at each nursing desk with these steps and possible interventions to implement. This is an ongoing process. All incidents and accidents are reviewed at QAPI for tracking and trending and further recommendations. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director or ARNP, NHA, DON, ADONS, QA Nurse, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators, Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises. 5. Completion 1/21/2016. 	1/21/16	

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 880 HIGH ST. BOWLING GREEN, KY 42101
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F 323	<p>Continued From page 17 incident/occurrence investigation forms.</p> <p>Record review revealed the facility admitted Resident #1 on 08/12/15 with diagnoses, which included Diabetes, Hypertension, Total Knee Replacement, and Anemia. Review of the Quarterly Brief Interview for Mental Status (BIMS) score, dated 12/04/15, revealed a score of fifteen (15) indicating the resident was interviewable.</p> <p>Review of the "Non-Pressure Skin Condition Record", dated 12/15/15, revealed a scrotal abrasion measuring six (6) centimeters (cm) in length by two (2) cm in width and 0.1 cm in depth with a partial thickness characteristic. Further review revealed there was no exudate and the wound bed was pink, pale tissue with slough, and the surrounding tissue was normal. It was noted the incident was caused by a pinched area by the CPM device.</p> <p>Interview with Resident #1, on 12/15/15 at 4:15 PM, revealed he had a sore on the scrotal area but could not remember how it happened. He stated Certified Nurse Aide (CNA) #7 found it when she was providing incontinent care on 12/15/15. Resident #1 further stated staff had been placing a towel under his scrotal area in order to keep it dry.</p> <p>Observation of Resident #1's skin assessment conducted by the Wound Care Nurse, on 12/16/15 at 2:55 PM, revealed a large oval shaped crater-like open area measuring six (6) centimeters (cm) x two (2) cm x 0.1 cm to Resident #1's scrotal area that had visible yellow tissue in the wound bed and slight yellow drainage.</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 650 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 18</p> <p>Interview with CNA #7, on 12/17/15 at 1:29 PM, revealed, on 12/15/15, while providing AM Incontinent care, she observed an area on Resident #1's scrotal area. She stated she immediately asked Unit Manager (UM) #4 and Charge Nurse #4 to come to the room to assess the area. She revealed UM #4 assessed the wound and Resident #1 told them the CPM machine had pinched him during therapy. She stated UM #4 reported this to Charge Nurse #4 and she immediately completed an investigation report. She stated Charge Nurse #4 stated she was going to have the Wound Care Nurse to look at the area for treatment.</p> <p>Interview with UM #1, on 12/17/15 at 1:45 PM, revealed she observed an open area on Resident #1's scrotal sac on 12/15/15 and the resident stated that he had been pinched by the CPM machine. She stated she told Charge Nurse #4 to complete an incident report and notify the Wound Care Nurse immediately.</p> <p>Interview with the Wound Care Nurse, on 12/18/15 at 1:35 PM, revealed the facility followed wound care guidelines protocol for wound care. She stated Resident #1 informed her that the CPM machine had pinched him and it caused an open area. She stated it was an abrasion measuring six (6) centimeters (cm) x two (2) cm x 0.1 cm on the posterior scrotal area. She revealed the physician was made aware and an order was received. The treatment was initiated immediately on the morning of 12/15/15. She stated the nurses usually do the CPM therapy with the resident. She further stated PT was supposed to evaluate the resident to determine if the injury was caused by the machine.</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
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F 323	<p>Continued From page 19</p> <p>Review of the Physician's Order, dated 12/15/15, revealed to apply Silvadene Cream to the abrasion to the scrotal area twice a day; however, there was no order for "PT to evaluate for current length/fit" until 12/16/15 at 4:30 PM.</p> <p>Review of the Therapy Records revealed Resident #1 received CMP therapy two (2) times (morning and afternoon) on 12/15/15 and 12/16/15 prior to PT evaluating the CMP machine to determine if it had caused the wound.</p> <p>Interview with the Rehab Manager, on 12/17/15 at 2:09 PM, revealed she had not been notified of the injury sustained by Resident #1 until the afternoon of 12/16/15 when she received a call from the Quality Assurance (QA) Nurse indicating that an order for a PT evaluation was needed.</p> <p>Interview with the QA Nurse, on 12/17/15 at 2:13 PM, revealed she had notified the Rehab Director, on 12/16/15, of the need for PT to evaluate Resident #1 for the proper operation of the CMP machine.</p> <p>Interview with PT #1, on 12/17/15 at 2:09 PM, revealed he was notified on 12/16/15 by the Rehab Manager that Resident #1 needed an evaluation related to a possible wound caused by the CPM machine. He stated he and PT #2 immediately went to the resident's room and completed an assessment of the CPM machine. He stated since the CPM machine was located approximately twelve (12) inches from the resident's scrotal area that he felt the CPM machine could not have caused the injury.</p> <p>Interview with PT #2, on 12/17/15 at 2:59 PM, revealed in his professional opinion the CPM</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	
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F 323	Continued From page 20 machine could not have caused the resident to become pinched. He stated that all areas of the machine are round and the hinged area of the machine is approximately twelve (12) inches from the resident's scrotal area. Interview with the DON, on 12/17/15 at 2:13 PM, revealed PT should have been notified immediately to come and assess the equipment and placement of the equipment if this was the known source of the cause of an injury. She stated waiting twenty-four (24) hours was not acceptable. She stated that PT should have been notified immediately to inspect the CPM machine to ensure it was working properly and that the same event did not reoccur.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure that residents receive proper treatment and care for one (1) of twenty-four (24) sampled	F 328	F328 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS 1. Resident #15 no longer resides in the facility. RN #1 who provided improper g-tube site care was given a coaching and counselling by the Director of Nursing on 12/21/2015. RN #1 also completed competency on proper g-tube care by the Staff Development Coordinator on 12/17/2015 and again on 1/8/2016. The Quality Assurance Nurse assessed resident #15 and developed a care plan for g-tube site care and received and order for g-tube site care and placed it on the TAR on 12/30/2015. 2. All residents with g-tubes were reviewed by the Quality Assurance Nurse on 12/30/2015 and each one had been assessed, a care plan was in place, and an order had been received and entered on the TAR for the g-tube care. Competency Check offs on g-tube site care was completed on all licensed nursing staff to ensure each nurse could perform the task correctly. This was completed on 1/20/2016. 3. All licensed staff were re-educated by the Staff Development Coordinator the proper way to perform g-tube care. Education was completed by 1/20/2016.	

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F 328	<p>Continued From page 21 residents related to gastrostomy (G-tube) site care (Resident #15).</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #15 on 10/02/15 with diagnoses, which included Cerebrovascular Accident and Diabetes Mellitus. Review of the Admission Minimum Data Set (MDS) Assessment, dated 10/09/15, revealed this resident was unable to complete a Brief Interview for Mental Status (BIMS) because he/she was rarely or never understood and this indicated he/she was not interviewable. In addition, the resident was assessed to have a tube feeding in place while at the facility.</p> <p>Review of the Comprehensive Care Plans for Resident #15, dated 10/09/15 and 10/13/15, and Physician's Orders, dated 12/2015, revealed there were no identified interventions related to G-Tube site care or providing G-Tube site care.</p> <p>Review of Resident #15's December 2015 Treatment Administration Records (TAR) revealed there was no G-Tube site care recorded on the TAR so licensed staff would be cued to perform.</p> <p>Observation, on 12/17/15 at 2:45 PM, revealed Registered Nurse (RN) #1 provided g-tube site care for Resident #15. Further observation revealed RN #1 failed to wash his hands and apply clean gloves prior to the procedure, used the same washcloth to clean the G-tube site twice, and failed to change gloves after removing the old dressing; and, after cleaning g-tube site and prior to applying a clean dressing per standards of practice.</p>	F 328	<p>(cont.)</p> <p>4. The Unit Managers and Staff Development Coordinators will observe 5 residents requiring g-tube care weekly x 4 weeks, monthly x 4 months and the results of observations will be reported to the QAPI committee for tracking and trending and further recommendations. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director or ARNP, NHA, DON, ADONs, QA Nurse, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators, Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises.</p> <p>5. Completion Date 1/21/2016.</p>	1/21/16

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 650 HIGH ST. BOWLING GREEN, KY 42101
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F 328	<p>Continued From page 22</p> <p>Interview with RN #1, on 12/17/15 at 3:00 PM, revealed he had forgot to change gloves but in hindsight should have changed gloves prior to starting G-Tube site care, after removing the old dressing, after removing brownish crust-like material from the G-Tube site and prior to placing the new dressing to Resident #15's G-Tube site. RN #1 also stated he should have had more supplies in place, to include a basin with warm water and additional wash cloths and he should not have used the same soiled wash cloth for a second time of cleansing Resident #15's G-Tube site due to the wash cloth was dirty from the first cleansing attempt.</p> <p>Interview with the Unit Manager (UM), on 12/17/15 at 4:09 PM, revealed she expected staff to have the appropriate supplies in place and ready prior to starting G-Tube site care and she expected staff to follow the facility's G-Tube site care policy/guidelines.</p> <p>Interview with the Director of Nursing (DON), on 12/18/15 at 2:50 PM, revealed she expected staff to have the appropriate supplies in place and ready prior to starting G-Tube site care and she expected staff to follow the facility's G-Tube site care policy/guidelines.</p> <p>Interview (Post Survey) with Licensed Practical Nurse (LPN) #5, on 12/30/15 at 10:47 AM, revealed Resident #15 should have had a physician's order for G-Tube site care upon admission which would have then been placed on the TAR for licensed staff to perform. She also stated a care plan should have been implemented in regards to G-Tube site care.</p> <p>Interview (Post Survey) with the Quality</p>	F 328		
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F 328	Continued From page 23 Assurance (QA) Nurse, on 12/30/15 at 11:30 AM, revealed Resident #15 should have had a physician's order for G-Tube site care upon admission, which would have then been placed on the TAR for licensed staff to perform. She also stated a care plan should have been implemented on admission in regards to G-Tube site care. She further stated the facility would be unable to determine if G-Tube site care had been completed routinely for Resident #15 because there was no physician's order for G-Tube site care for Resident #15, nor was G-Tube site care listed on Resident #15's TAR for licensed staff to initial that care had been completed. Interview with the Administrator, on 12/30/15 at 11:40 AM, revealed she expected staff to be sure a resident with a G-Tube had a physician's order upon admission in regards to G-Tube site care, and additionally, a care plan should have been implemented in regards to G-Tube site care for Resident #15 upon admission.	F 328		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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F 441	Continued From page 24 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of infection. Staff exited two (2) resident rooms (Resident #8 and Resident #15) with the soiled wash cloths and towels exposed and not contained after performing urinary catheter and gastrostomy tube site care.	F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPRED, LINENS 1. Resident # 15 no longer resides in the facility and resident #8 suffered no ill effects. All staff members have been re-educated by the Staff Development Coordinator on handling soiled linens and the Infection Control by 1/20/2016. 2. 10 Staff members are being observed daily x 5 days by DON/ADONS/Unit Managers to determine if any other staff is handling soiled linens improperly and the Staff Development Coordinator has been reviewing the Infection Control Policy with all staff. 3. All nursing staff have been re-educated by the Staff Development Coordinator concerning proper handling of soiled linens, handwashing, Foley catheter tubing placement and Foley catheter care and licensed staff also received additional education concerning g-tube care by 1/20/2016. 4. 5 staff members are being observed by Unit Managers/ADONS/DON for improper soiled linen handling, improper g-tube and Foley catheter care. The observations are being done weekly x 4 weeks, then monthly x 3 months with results presented in QAPI for tracking and trending and further recommendations. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director or ARNP, NHA, DON, ADONS, QA Nurse, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators., Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises. 5. Completion 1/21/2016.	1/21/16	

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F 441	<p>Continued From page 25</p> <p>The findings include:</p> <p>Review of facility policy, titled "Standard Precautions", last revised 08/2007, revealed standard precautions apply to the care of all residents in all situation regardless of suspected or confirmed presence of infectious diseases. Further review of the policy revealed, staff are to handle, transport and process linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membranes exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments.</p> <p>1. Observation of Registered Nurse (RN) #1, on 12/17/15 at 3:00 PM, revealed RN #1 provided G-Tube site care for Resident #15. RN #1 placed a soiled washcloth and a soiled towel into Resident #15's sink after using the items for G-Tube site care. After completion of G-Tube site care, RN #1 grasped these soiled linen items out of Resident #15's sink and carried them into the hallway, exposed and not contained, and walked to the soiled linen cart and placed the items in the cart. Further observation revealed the cart was in the hallway, approximately ten (10) feet from Resident 15's room.</p> <p>Interview with RN #1, on 12/17/15 at 3:00 PM, revealed he should not have placed soiled linen in the resident's sink, and he should have had a bag available for the soiled linen. He also stated it was not acceptable to take unbagged soiled linen into the hallway.</p> <p>2. Observation of RN #2, on 12/17/15 at 1:10 PM, revealed RN #2 provided urinary catheter care for Resident #8. RN #2 placed a soiled</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 660 HIGH ST. BOWLING GREEN, KY 42101		
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F 441	<p>Continued From page 26</p> <p>washcloth and a soiled towel in Resident #8's sink after using the items for urinary catheter care. After RN #2 positioned Resident #8 and covered the resident with a blanket, she grabbed the linen from the sink and carried them into the hallway, exposed and not contained, and placed the dirty linen in the soiled linen cart, which was in the hallway approximately five (5) feet from Resident #8's room.</p> <p>Interview with RN #2, on 12/17/15 at 1:30 PM, revealed she would expect anyone providing catheter care to use a plastic bag to store soiled linens. She stated soiled linen should never be placed in a resident's sink and soiled linen should not be taken out of a resident's room into the hallway without being in a bag and contained.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 12/17/15 at 1:35 PM, revealed staff are to have a plastic bag to place soiled washcloths and towels in, and should not place the soiled washcloths and towels in a sink. CNA #3 further stated soiled linen was not to be transported in the hall unless it was in a bag.</p> <p>Interview with the Unit Manager (UM), on 12/17/15 at 4:09 PM, revealed she expected staff to store soiled linen in a bag when providing care for residents, and soiled linen should not be placed or stored in a resident's sink. She also stated soiled linen needed to be placed in a bag and contained prior to being taken out of a room into the hallway.</p> <p>Interview with the Director of Nursing (DON), on 12/18/15 at 2:50 PM, revealed she expected staff to use a bag to place soiled line into when providing care for resident and soiled linen should</p>	F 441			

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F 441	Continued From page 27 not be placed or stored in a resident's sink. She also stated soiled linen needed to be in a bag and contained prior to being taken out of a resident's room into the hallway.	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 01/21/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(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 000}	INITIAL COMMENTS Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance on 01/08/16.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X8) DATE

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185089	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 1/21/2016	Y3
NAME OF FACILITY SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # <u>NFPA 101</u> LSC <u>K0038</u>	Correction Completed 01/08/2016	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) <u>DH</u>	DATE <u>01/27/16</u>	SIGNATURE OF SURVEYOR <u>Deborah C. Herdison, RPT, DR</u>	DATE <u>01/27/16</u>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/18/2015	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 850 HIGH ST. BOWLING GREEN, KY 42101
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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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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1988

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type III (200)

SMOKE COMPARTMENTS: Ten (10) smoke compartments

FIRE ALARM: Complete automatic fire alarm system

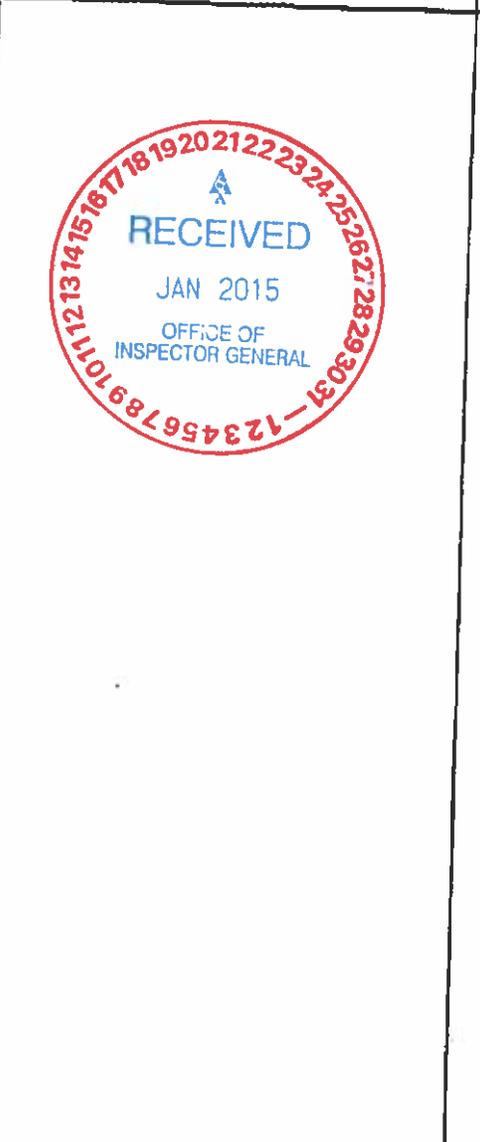
SPRINKLER SYSTEM: Complete automatic dry sprinkler system.

GENERATOR: Type II generator. Fuel source is diesel.

A Standard Life Safety Code Survey was conducted on 12/18/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred seventy-six (176) beds with a census of one-hundred thirty-six (136) 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)

K 000



(X5) COMPLETION DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephanie Hindsey</i> Administrator	TITLE	(X6) DATE 1/21/2016
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B WING _____	(X3) DATE SURVEY COMPLETED 12/18/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 560 HIGH ST. BOWLING GREEN, KY 42101	
(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 000	Continued From page 1	K 000		
K 038 SS=D	<p>Deficiencies were cited with the highest deficiency identified at a Scope and Severity of "D".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain exits according to National Fire Protection Association (NFPA) standards. This deficient practice affected one (1) of ten (10) smoke compartments, staff and approximately twenty-two (22) residents. The facility has the capacity for 178 beds with a census of 138 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour, on 12/18/15 at 10:00 AM with the Director of Maintenance (DOM), an exterior exit was observed leading to a locked gate in the Court Yard area. The lock was a coded key pad type with the code to exit posted. This exit must be illuminated under all lighting conditions in case of fire or other emergency.</p>	K 038	<p>K 038 NFPA 101 LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> The Director of Maintenance installed a light to illuminate the gate exit area leading to the Court Yard area on 1/7/2016. All other exits were reviewed for illumination on 12/18/2015 and all other exit areas had working lights. The Maintenance Department was educated on ensuring that all exits are properly lit by the NHA on 1/7/2016. The Maintenance Director will complete the QAPI form titled, "Environmental Safety Survey-Overall" monthly times 3 months and turn the completed form in to the QAPI committee QAPI for tracking and trending and further recommendations. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director or ARNP, NHA, DON, ADONs, QA Nurse, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MOS Coordinators., Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises. Completion date 1/8/2016 	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 659 HIGH ST. BOWLING GREEN, KY 42101		
(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 2 Interview with the DOM, on 12/18/15 at 10:00 AM, revealed he would add a light in this area to illuminate the gate/exit area. The findings were revealed to the Administrator on exit. Reference: NFPA 101 2000 edition 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.	K 038			