

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

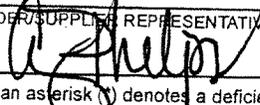
PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185435	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/13/2012
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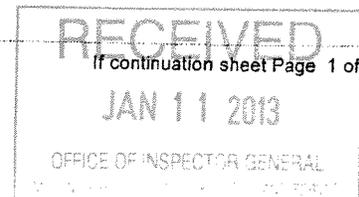
NAME OF PROVIDER OR SUPPLIER MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1381 CAMPBELL LANE BOWLING GREEN, KY 42104
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F 000	INITIAL COMMENTS A standard health survey was initiated on 12/11/12 and concluded on 12/13/12 with a Life Safety Code Survey initiated and concluded on 12/11/12. Deficiencies were cited with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Magnolia Village Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to ensure the survey results were available for examination in a place readily accessible to residents and failed to post the correct notice of availability. The findings include: No policy was provided by the facility. Observation of the Survey Results Poster, on 12/11/12 at 10:00 AM, revealed there was not an	F 167	The book containing the last three years of survey results was placed inside of the resident care area easily accessible by the residents and their responsible parties by the Administrator on 12/13/12. Signage was replaced by the Administrator for the notification of the availability of survey results in the lobby and placed in the resident care area on 12/13/12. Current residents and/or responsible parties were notified by letter on 1/8/13 of the location of the survey results by the Administrator.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/10/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 167 Continued From page 1 appropriate posting as required by regulation.

Interview with the Administrator, on 12/13/12 at 5:57 PM, revealed she was not aware of a required posting stating to have the survey results made available, in an area assessable to residents and family members. The poster that was provided was from the Corporate Office. The Administrator stated she did not think the Corporate Office was aware the poster was not the appropriate posting.

Observation, on 12/11/12 at 7:00 AM, revealed a binder in the lobby to the facility labeled "Public Information Book". The lobby was behind locked doors to enter or exit the resident population which made it inaccessible to residents.

Interview, on 12/13/12 at 8:05 AM, with Licensed Practical Nurse (LPN) #3 revealed residents could not exit the door to the lobby unless a staff member pressed a button to unlock the door.

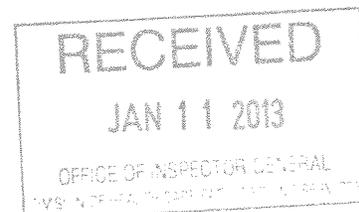
Interview with the family member of Resident #2, on 12/13/12 at 9:40 AM, revealed they had seen the book titled Public Information. The family member revealed thinking it might be resident rights. The family member stated they had never seen the State survey inspection results book and had wondered where it was located. The family member revealed they had never seen signage or postings regarding survey results. When told what the book titled Public Information contained, the family member replied they would never have thought to look there for survey results.

Interview, on 12/13/12 at 8:07 AM, with the Director of Nursing (DON) revealed a resident

F 167 The survey binder will be updated upon any survey with the survey results both in the lobby and the resident care area by the Administrator. Administrator was re-educated by Regional Vice President on F167 on 12/13/12.

Administrator will review survey results binder and signage for placement and completion every month for three months then quarterly. Administrator will report findings to Performance Improvement Committee monthly for three months then quarterly for further recommendations.

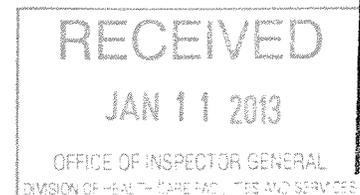
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F 167	Continued From page 2 could not go into the lobby area where the survey results book was located, unless a staff member took the resident out.	F 167			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policies, it was determined the facility failed to provide an ongoing program of activities designed to meet the needs, interest, and the physical, mental, and psychosocial well being for five (5) of the sixteen (16) sampled residents and six (6) Unsampled Residents. Residents #1,#2,#4,#10, and #12. The findings include: Review of the facility's policy regarding Activity Assessment and Documentation, dated 04/2010, revealed the Activity Director was responsible for coordinating, obtaining, charting, and/or filing documentation including: program participation record; one-to-one activity log; progress notes denoting the resident's engagement in programming as it relates to their physical, emotional, spiritual, and functional well being; activity care plan therapeutic goals updated quarterly, and upon readmission or significant change; and care area assessments (CAA) and	F 248	F 248 Residents #1,2,4,10and 12 were reassessed and the activity care plans were reviewed and revised by the Solana Program Director on 12/14/12 to meet their individual needs in accordance with their physical, mental, and psychosocial well-being. Activity assessments were completed on current residents by the Solana Program Director on 1/11/13 and care plans were revised as to meet the interests and physical, mental, and psychosocial well-being of each resident Activity Director was re-educated by the Solana Program Director on 12/13/12 to include an ongoing program of activities designed to meet in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident, developing the monthly calendar and updating with changes. The MDS coordinator was re-educated by the Administrator on 1/07/13 to assure the MDS/Care Plan is completed in full by all disciplines timely and care plan printed.		



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Continued From page 3
care plans as indicated by the Minimum Data Set (MDS) process. The policy statement revealed it was the center's policy to assess each resident's physical, mental, spiritual, psychosocial, and leisure interests for engagement in activities based on past and present patterns and interest.

Review of the facility's policy regarding Care Plan-Interdisciplinary, dated 01/2008, revealed the Interdisciplinary Team (IDT) develops care plans addressing the resident's most acute problems. The care plan is comprehensive for each resident including measurable objectives and timetables to meet resident's medical, nursing, and mental and psychosocial needs. The IDT reviews each care plan at least quarterly with updates as necessary.

1) Review of Resident #2's clinical record revealed the facility admitted the resident on 01/23/09 with diagnoses of Dementia, Weakness, Anxiety, Depression, and Episodic Mood Disorder. The resident was assessed by the facility as requiring one (1) to two (2) person assist transferring, dressing, eating, hygiene, and locomotion. On 11/29/12, the resident became active with Hospice for Failure to Thrive. Review of the resident's comprehensive plan of care revealed the facility did not have a care plan for the resident's activities.

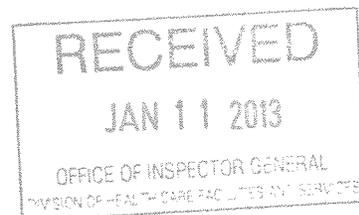
Observation of Resident #2, on 12/11/12 at 12:33 PM, revealed the resident was sitting in the dining room being fed lunch with the assistance of a certified nursing assistant (CNA). The resident frequently nods head back and forth, but made no attempt to move upper extremities, take utensils, or touch the staff.

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The Solana Program Director will review five resident records per week for one month and then five resident records per month for two months then quarterly to include an ongoing program of activities is designed to meet, in accordance with the comprehensive assessment, and the interests and physical, mental, and psychosocial well-being of each resident. The Solana Program Manager will report findings to the Performance Improvement Committee monthly for three months and then quarterly for further recommendations.

Completion Date:

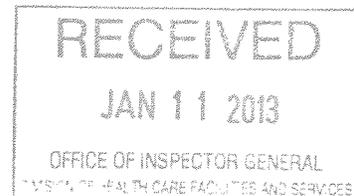
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F 248	Continued From page 4 Observation of Resident #2, on 12/12/12 at 9:50 AM, revealed the resident was sitting in a wheelchair in the dining room in the back of the group during the Shake Awake Memory activity. No response was noted during activity. Interview with the Activities Director (AD), on 12/13/12 at 2:20 PM, revealed she did remember developing a care plan for activities and did not know what had happened to the plan of care. The AD revealed Resident #2 was low functioning and would be appropriate for sensory stimulation and not appropriate to initiate their own activity. She was given a list from the MDS Coordinator when assessments were completed and did not remember developing a care plan for resident #2 and did not know why it was missed. The facility Program Director provided a care plan for resident #2, on 12/13/12 at 4:30 PM, review of the care plan revealed a focus for the resident to self initiate activities which was scratched out and revised with hand written items and several hand written interventions. The Program Director revealed the care plan was just printed and hand written items were just added to update the care plan to reflect the residents current ability and function. The Program Director revealed she did not know why a care plan was not in the medical record or why it had not been revised. 2) Review of Resident #4's clinical record revealed the facility admitted the resident on 04/07/09 with diagnoses of Dementia and Cognitive Communication Deficit. The resident triggered a CAA for activities based on the facility's MDS assessment dated 03/22/12.	F 248			



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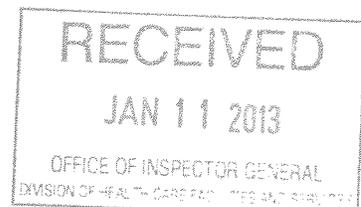
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F 248	<p>Continued From page 5</p> <p>Review of the comprehensive plan of care revealed a care plan for activities had not been developed.</p> <p>Interview with the Activities Director, on 12/13/12 at 2:20 PM, revealed she was given a list from the MDS Coordinator when assessments were completed and did not remember developing a care plan for resident #2 and did not know why it was missed.</p> <p>3) Review of Resident #12's clinical record revealed the facility admitted the resident on 12/03/04, with diagnoses of Dementia with Behavioral Disturbances, Contracture of Joint, Weakness, Depression, and Alzheimer's. The resident received Hospice care and triggered a CAA in activities based on the facility's MDS assessment for 08/30/12. The Activity/Recreation assessment, dated 08/30/12, revealed the resident's interests includes massage and multi-sensory stimulation. Review of the residents comprehensive plan of care revealed the facility's goal was to participate in low stimulation activities and receive sensory stimulation. The facility's only care plan intervention was to transport to resident activities. Review of the activities calendar for November and December revealed there were no sensory activities scheduled.</p> <p>Observation of Resident #12, on 12/13/12 at 10:15 AM, revealed the resident was in their room, lying in bed covered with a blanket while a group activity consisting of story telling discussing unusual or strange laws was taking place in the TV area. Observation, on 12/13/12 at 10:40 AM, revealed the resident was still in bed while a nail</p>	F 248		
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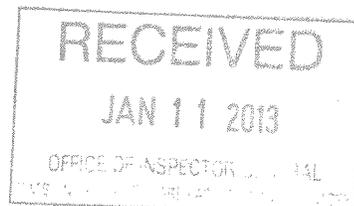
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F 248 Continued From page 6
care and hand massage group was taking place in the dining room.

Interview with Registered Nurse (RN) #1, on 12/13/12 at 1:55 PM, revealed resident #12 was not very responsive and occasionally would make eye contact and acknowledge staff. The RN revealed sometimes the resident was out in a group activity but most of the time the resident was in the bed. The RN revealed he was not sure if the facility offered sensory stimulation.

Interview with the Activities Director (AD), on 12/13/12 at 2:20 PM, revealed sensory stimulation consisted of massage with scented lotions, or letting the residents smell flowers. The AD revealed the calendar consisted of more active recreation and the department fills in with other things. The AD revealed a sensory session was done during nail care on 12/13/12 in the dining room. The AD revealed lotion was used with the nail care, therefore, sensory was provided to the residents who were already in the room. However, when asked who was in attendance, the AD revealed the participants in sensory were not appropriate for a sensory activity, as they were higher functioning. The AD revealed sensory was more appropriate for residents that were lower functioning and were not able to participate in the active types of recreation. The AD revealed she determined who were the lower functioning residents and also looked at documentation to see who had not participated in activities. The AD revealed the sensory activity was not done appropriately, or on the appropriate residents. The AD revealed Resident #12 did require special care and sensory stimulation and would have been

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F 248 Continued From page 7

appropriate for the sensory session. The AD revealed activities provided residents with meaningful activity to make them feel needed, and care plans were to let everyone know what residents like to do now as well as in the past. The AD revealed she was responsible to develop and revise resident activity care plans and ensure appropriate activities were being provided.

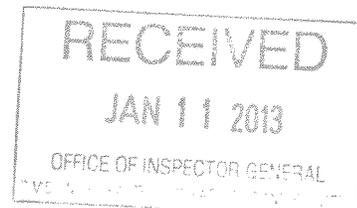
Interview with the Program Director, on 12/13/12 at 2:50 PM, revealed she was responsible to ensure activities were being done and that care plans were developed, updated and appropriate to resident. The Program Director revealed she did audits and should have noticed that the care plans were not being done.

Interview with the Director of Nursing, on 12/13/12 at 3:37 PM, revealed she was a member of the IDT but did not monitor the activity care plans.

4) Record review of the clinical record for Resident #1 revealed the facility admitted the resident on 10/28/10 with diagnoses of Alzheimer's Disease, Dementia, Hypertension, Difficulty Walking and Anxiety Disorder. Resident #1 was assessed as non-interviewable by the facility on 09/11/12 using the Resident Assessment Instrument (RAI). In addition, Resident #1 was assessed to have inattention and disorganized thinking.

Observation, on 12/11/12 at 2:55 PM, in the Activity Room, revealed Resident #1 sitting in a wheelchair. An activity was taking place where the activity person was engaging residents in a group conversation activity. Resident #1 was observed not participating.

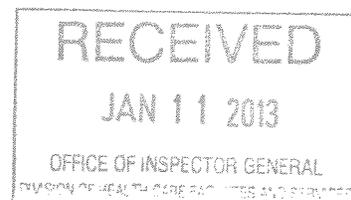
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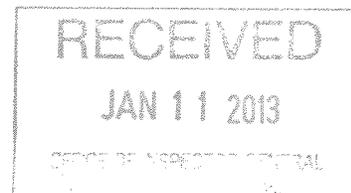
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F 248	Continued From page 8 Observation, on 12/12/12 at 7:50 AM, in the dining room, revealed staff encouraged Resident #1 to eat his/her breakfast meal. Resident #1 was sitting in a wheelchair with a lap buddy placed on the wheelchair. Interview, on 12/12/12 at 8:00 AM, with Resident #1 while he/she was sitting in a wheelchair in the television room revealed Resident #1 was not looking at the television. Resident #1 was asked if he/she was watching television. Resident #1 responded "If that is what's on." Resident #1 then attempted to enter the therapy room, located next to the television room. Resident #1 was redirected out of the therapy room. Resident #1 required direction where to go. The resident could propel his/her own wheelchair. Record review of the care plan for Resident #1 revealed Resident #1 would self-initiate his/her own activities. The Focus stated Resident #1 enjoyed sewing, conversing with others and playing word and active games. The date this Focus area was initiated on 03/11/11. The revision date was 09/26/12. During one (1) year and nine (9) months, the Focus did not update with the condition of Resident #1. The activity program for Resident #1 did not match the current skills and abilities of the resident. Interview, on 12/12/12 at 2:30 PM, with Registered Nurse (RN) #1 revealed to self-initiate means to start doing an activity by yourself. He stated Resident #1 required guidance for activities. Interview, on 12/12/12 at 2:42 PM, with the	F 248			



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F 248	<p>Continued From page 9</p> <p>Director of Nursing (DON) revealed Resident #1 could not say he/she wanted to do something.</p> <p>Interview, on 12/12/12 at 3:40 PM, with the Activities Director revealed to self-initiate means someone who could vocalize what they would like to do or do an activity by themselves. She revealed she was a part of the Interdisciplinary Team (IDT). She revealed the care plan was updated annually, or with a change in the condition of the resident. She stated Resident #1 could not self-initiate activities.</p> <p>5) Record review of Resident #10's clinical record revealed the facility admitted the resident on 12/02/12, with diagnoses of Alzheimer Disease, Dysphagia Oropharyngeal Phase, Altered Mental Status, Anxiety, Lack of Coordination, Abnormality of Gait, Cardiac Dysrhythmias, Essential Hypertension, Anemias, and Symbolic Dysfunction.</p> <p>Observation of Resident #10, on 12/13/12 7:54 AM, revealed Resident #10 sitting in a wheelchair and unable to talk and make his/her needs known.</p> <p>Record review of Resident #10's activities of daily living care plan revealed a self care deficit of weakness, unstable health condition, cognitive impairment, decreased balance, impaired coordination related to Alzheimer dementia.</p> <p>Record review of Resident #10's activities care plan, revealed the resident would self initiate</p>	F 248	



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F 248 Continued From page 10
activities and enjoyed playing cards and checkers. The goal was for the resident to continue to participate in self initiated acts 2 x per week.

Interview with the Activities Director, on 12/13/12 at 2:28 PM, revealed Resident #10 enjoyed visits with his/her wife daily, loved the hand care and massage and the music program. Resident #10 was more lower functioning. The Activities Director stated, she was confused by the statement initiation on an activity. The Activities Director stated she would set a coloring book in front of the resident and the resident would start to color on his/her own. She further stated she forgot to update the care plan.

Interview with the Activities Supervisor, on 12/13/12 2:40 PM, revealed Resident #10 would not be able to initiate an activity by him/her self.

F 252 SS=E 483.15(h)(1)
SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

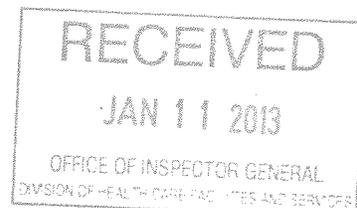
The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to provide a homelike environment, one that de-emphasized the institutional character of the facility, for eighteen (18) of sixty (60) resident rooms. Rooms 1A, 3A and B, 4A, 6B, 7A, 8A and B, 9A

F 248

F 252 F252

Rooms 1A, 3A and B, 4A, 6B, 7A, 8A and B, 9A and B, 10B, 11A, 23A, 29B, 30A, 32B, and 35A and B were decorated with homelike décor by the Director of Marketing and Admissions/Social Services on 1/11/13. Families and or responsible parties were notified by the Administrator on 1/03/13 to provide personal items to support a homelike environment and link them to the past.



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F 252 Continued From page 11 and B, 10B, 11A, 23A, 29B, 30A, 32B and 35A and B.

The findings include:

The facility did not provide a policy for environmental rounds.

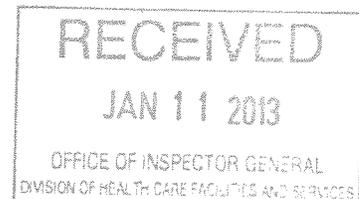
Observation, on 12/11/12 during the tour of the facility which began at 7:00 AM, revealed resident rooms on the 100 Hall lacked personal items and pictures to support a homelike environment and encouraged links with the past. Those rooms were 1A, 3A and B, 6B, 7A, 8A and B, 10B and 11A.

Observation, on 12/11/12 at 9:25 AM, revealed Resident F in his/her room, Room 6B, questioning where he/she was and was a family member coming to pick him/her up. The room contained one small wedding picture of Resident F in the window area. There were no other items visible in the room to link Unsampled Resident F to the past or make the room his/her own. The room of Unsampled Resident F presented as institutional with the lack of personal items or pictures.

Observation, on 12/12/12 during an environmental tour of the facility which began at 3:00 PM, revealed additional resident rooms, Rooms 4A, 9A and B, 23A, 29B, 30A, 32B 35A and B, presented as institutional in character based on the lack of personal items and/or pictures in the resident rooms. The facility was a Dementia/Alzheimer's facility and these rooms lacked a connection with the past.

F 252 A review of current resident rooms was completed by the Director of Marketing and Admissions/Social Services on 12/14/12 to assess for homelike environment. A letter was mailed to responsible parties encouraging them to provide personal items to support a homelike environment and link them to the past. Rooms were appropriately decorated to be homelike as of 1/11/13 by the Administrator and Director of Marketing and Admissions/Social Services.

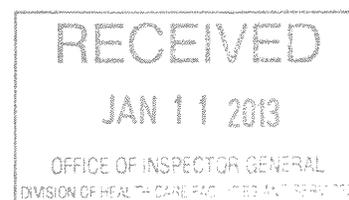
The Director of Admissions and Marketing/Social Serves was re-educated by the Administrator on 1/8/13 to encourage family members to provide personal belongings to support a homelike environment that recognizes the individuality and autonomy of the resident that provides an opportunity for self-expression and encourages links with the past and family members to be reviewed during the admission process.



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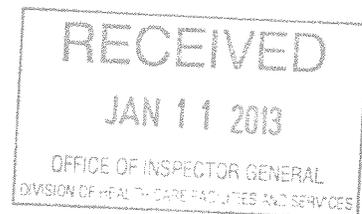
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F 252	<p>Continued From page 12</p> <p>Interview, on 12/12/12 at 8:00 AM, with the Therapy Program Director revealed a homelike room would be cozy and warm. She revealed the room would have the personal things of the resident, that way it would be a familiar environment to the resident. She stated it was important for residents with Dementia and Alzheimer's to have their familiar things around them as it calms their behavior. As the Therapy Program Director toured the 100 Hall, with this surveyor, she revealed she thought the residents had more of their personal things in their rooms than were present.</p> <p>Interview, on 12/12/12 at 8:10 AM, with the Director of Nursing revealed a homelike environment would have pictures of family and ones favorite items present. The reason for this, she revealed, was so the resident would be more comfortable and have something to connect to. She revealed the facility was responsible for creating a homelike environment if the family did not provide items for the resident.</p> <p>Interview, on 12/12/12 at 8:22 AM, with the Administrator revealed a homelike environment was based on the personal preference of the resident or their family. However, the facility had no residents that were interviewable, based on the MDS assessment conducted by the facility, to say what would constitute a homelike environment to them. The lack of personal items in the resident's rooms indicated that some families were not providing for a homelike environment. She revealed the facility would promote the environment.</p> <p>Interview, on 12/12/12 at 4:10 PM, with Certified</p>	F 252	<p>The Director of Admissions and Marketing/Social Services will review three rooms per week for four weeks and five rooms per week for two months then quarterly to include personal belongings and décor to support a homelike environment. The Director of Admissions and Marketing/ Social Services will report findings to the Performance Improvement Committee monthly for three months then quarterly for further recommendations.</p> <p>Completion Date: 1/14/13</p>		



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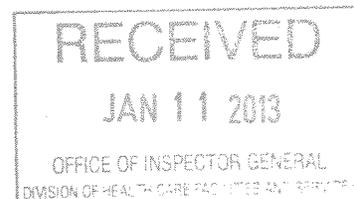
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F 252	Continued From page 13 Nursing Assistant (CNA) #5 revealed the residents who were without personal items and pictures in their room was because the family did not provide those items.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's Work Order Log and the Work Schedule, it was determined the facility failed to provide effective maintenance services for all doors to resident rooms and to side tables in resident rooms 31B, 35B, 37 and 38A. In addition, the facility failed to maintain wheelchairs for one (1) of the sixteen (16) sampled residents and five (5) if six (6) unsampled residents. Residents #4, and Unsampled Residents A, B, C, D and E, all having torn or cracked arms on their wheelchairs. The findings include: 1. Record review of the facility Work Schedule for the month of December 2012 revealed the facility was to inspect the doors every three months. There was a check mark in a box next to and a line drawn through the statement "Facility Inspection: Conduct facility door inspection (Every 3 months)". Observation, on 12/11/12 during the facility tour which began at 7:00 AM, revealed all resident	F 253 F 253	Resident #4 wheelchair was repaired by the Maintenance Director on 12/13/12. The side tables in rooms 31B, 35B, 37 and 38A were repaired on 1/10/13. Doors were repaired by the Maintenance Director on the 100 hall way and the bathroom of room 3 on 1/10/13. A review was conducted of the Resident care area by the Maintenance Director and the Administrator on 12/21/12 to assess for sanitary, orderly and comfortable environment to include doors, side tables and wheelchairs. Repairs were conducted by the Maintenance Director on 12/14/12 for the side tables and wheelchairs. Kick plates were ordered by the Maintenance Director on 1/09/13 for all resident and bathroom doors to be completed by Inpro Corporation.	



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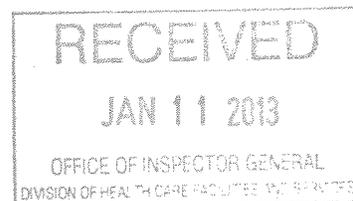
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F 253	Continued From page 14 doors on the 100 Hall had scratches, dark brown horizontal lines discoloring the doors and the bathroom door in Room 3 had bare wood exposed. Observation, on 12/12/12 during an environmental tour which began at 3:00 PM, revealed all doors to resident rooms had significant scratches and dark brown horizontal lines discoloring the doors. In addition, the side tables in Rooms 31B, 35B, 37 and 38A had scratches on the edging to the top of the table down to the particle board. Interview, on 12/12/12 at 3:05 PM, with the Maintenance Supervisor revealed he was aware of the condition of the doors in the facility. He revealed a bid had been placed during the summer to have kick plates placed on the doors below the doorknob. However, he revealed the facility was sold to another company and the door issue was dropped. He revealed the appearance of the resident doors were not like the appearance of doors you would have in your home. 2. Record review of the facility Work Schedule for the month of December 2012 revealed there was no listing for wheelchairs. There was also no Preventative Maintenance for wheelchairs to monitor the wheelchairs for needed repairs which were performed by maintenance. Record review of the maintenance Work Order Log for current work orders on 12/11/12, the first day of the survey, revealed there were no outstanding work orders for the repair of torn	F 253	Re-education provided to staff by the Administrator and the Director of Nursing on 1/08/13 regarding maintaining the resident care environment and notification to the Maintenance Director of environmental repair needs such as scuffs on doors and side tables as well as tears in wheelchair arms. Administrator will conduct facility rounds once a week for one month then quarterly to assess for sanitary, orderly and comfortable environment. The Administrator will report findings to the Performance Improvement Committee monthly for three months then quarterly for further recommendations. Completion Date:	01/14/13



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F 253	<p>Continued From page 15 wheelchair arms.</p> <p>Observation, on 12/11/12 at 7:30 AM, revealed a torn right wheelchair arm on Resident A's chair, cracked wheelchair arms on the chair of Resident B, a tear on the right wheelchair arm of Resident C, a right wheelchair arm tear for Resident #4, a torn left wheelchair arm on Resident D's chair and a right torn wheelchair arm on the wheelchair of Resident E.</p> <p>Interview, on 12/12/12 at 3:57 PM, with Certified Nursing Assistant (CNA) #2 revealed that the CNA was responsible to report the need for a wheelchair repair to the Nursing Supervisor. The Supervisor would then write it down in the maintenance book and maintenance would repair the chair. There were no current requests for wheelchair repair in the maintenance book.</p> <p>Interview, on 12/12/12 at 4:00 PM, with CNA #3 revealed maintenance did the repairs on the wheelchairs. She revealed whoever sees the need for repair was the one to report it. She revealed she had been in-serviced on reporting wheelchairs in need of repair. However, based on the number of wheelchair arms in need of repair, the in-service had not been successful. She revealed not reporting the need for repair to the wheelchair arm may cause skin tears to the resident.</p> <p>Interview, on 12/12/12 at 4:10 PM, with CNA #5 revealed all CNA's or any member of the nursing team could report the need for wheelchair repair. It was written in a book that generated work orders. He revealed wheelchairs in need of repair were to be reported immediately. He</p>	F 253		



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F 253 Continued From page 16
revealed he had been in-serviced and failure to report could result in a skin tear to a resident with a torn wheelchair arm.

F 253

Interview, on 12/12/12 at 2:50 PM, with the Director of Nursing (DON) revealed nursing was responsible to note if there were wheelchairs in need of repair and maintenance would repair the chair with a work order.

F 309
SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

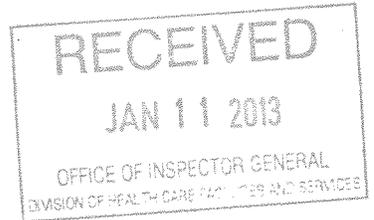
F 309 F 309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Resident #2's care plan was obtained from hospice on 12/14/12 and reviewed by the Director of nursing and found that a coordinated plan of care that clearly delineates the services to be provided by Hospice was placed in the Medical record and interventions correlate with centers plan of care. Resident # 10's wheelchair was re-evaluated by the Therapy Program Manager on 12/14/12 and recommendation made for a new wheelchair cushion was put into place on 12/24/12 to elevate resident and better accommodate stature.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's Hospice Services Agreement, it was determined the facility failed to ensure coordination of care was consistent with Hospice care in accordance with the Hospice contract for one (1) of the sixteen (16) sampled residents and six (6) unsampled residents. Resident #2. In addition, the facility failed to reassess Resident #10 for the appropriateness of an assisted device used as an intervention for falls.

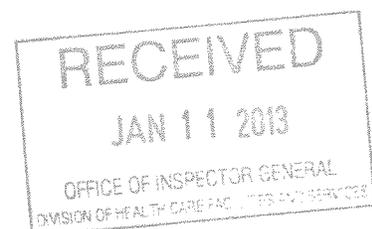
The findings include:



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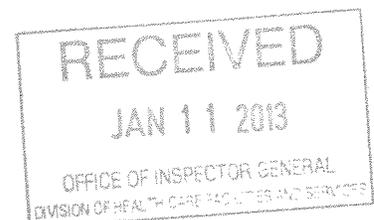
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F 309	Continued From page 17 Review of the facility's Hospice Services Agreement, entered into on 03/01/2011, revealed in Addendum A that a Plan of Care (POC) means a coordinated plan of care for an individual that clearly delineates the services to be provided by Hospice and Center; was based on an assessment of medical, physical, psychological, and social needs and unique living situation; reflects the participation of Hospice, Center, the patient and patient's family, as appropriate, and complies with federal and state laws and regulations. Hospice and Center shall jointly develop and agree upon the patient's POC. Hospice and Center each shall maintain a copy of each patient's POC in the respective clinical records maintained by each party. Section 6.9, a current POC shall be maintained in a manner immediately accessible to both parties for review, inspection, and proper evaluation, screening, and provision of services under this agreement. Observation of Resident #2 during a skin assessment with Registered Nurse (RN) #1, on 12/12/12 at 10:15 AM, revealed the Hospice nurse was in the room watching the skin assessment being done and taking notes. The Hospice nurse and the facility nurse discussed pain medication when facial grimacing and moaning was noted from the resident. Review of Resident #2's medical record revealed the resident was admitted into Hospice services on 11/29/12 for Failure to Thrive. A comprehensive POC for Hospice services was not in the medical record and was not available in the facility for review. Interview with the Hospice Nurse, on 12/13/12 at	F 309	Current residents receiving hospice services care plans were reviewed on 12/14/12 by the Director of Nursing and found to have Hospice care plans in the medical records with a coordinated plan of care. A review was completed for residents using wheelchairs for mobility by the Therapy Program Manager in collaboration with the Director of Nursing on 1/10/13. Wheelchairs were found to be appropriate and care plans in place to reflect the resident's current needs. MDS Coordinator was re-educated on the coordination of benefits with Hospice related to the Plan of Care to include reviewing the Hospice plan of care on the medical record within the time frame of the contract, to correlate the interventions and including the Hospice representative in the Interdisciplinary Care Plan meetings on 1/07/12 by the Administrator. Staff re-education provided by the Assistant Director of Nursing completed on 1/08/13 regarding wheelchair positioning and referral to therapy for screenings.		



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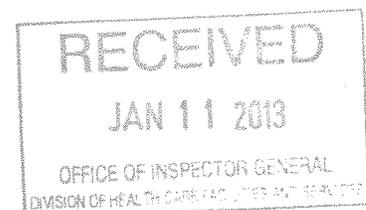
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F 309	<p>Continued From page 18</p> <p>11:05 AM, revealed she was the assigned nurse but was on vacation when the resident was admitted into Hospice services. The Hospice nurse revealed a POC was initiated on admission, it was completed, but was not placed on the resident's facility medical record. The nurse revealed she was aware it should have been placed in the resident's medical record. The Hospice nurse revealed she could not remember the time frame it was due to be placed on the chart and would have to refer to policy and procedure; however, the nurse revealed it definitely should have already been placed on the resident's medical record. When asked how coordination of care was being achieved without the Hospice POC, the nurse replied she reviewed the facility's POC.</p> <p>Review of the facility's POC revealed the Hospice nurse had signed the care plan for Hypothyroidism as read and reviewed.</p> <p>Interview with RN #1, on 12/13/12 at 1:55 PM, revealed the skin assessment on 12/12/12 was the first time Hospice had seen the resident's skin. The RN revealed Hospice staff will let us know if they noticed anything, but they pretty much took care of the resident like they always have. When asked how coordination of care was being achieved, the RN revealed he was not sure how Hospice worked, but did not see any difference between Hospice and the facility's care. The RN revealed he did not know if Hospice was supposed to have a POC, but felt that they should because it gave them a measurable goal.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 309	<p>The Director of Nursing will review two charts per month for three months than one per quarter with Hospice services to include reviewing the Hospice plan of care is on chart within the time frame of the contract, and coordination of benefits are reflected in the plan of care. The Director of Nursing will review five residents per week for four weeks, three residents per week for four weeks and five residents per month for one month then five per quarter for wheelchair positioning and referral to Occupational Therapy. The Director of Nursing will report findings to the Performance Improvement Committee for three months then quarterly for further recommendations.</p> <p>Completion Date:</p>	1/14/13



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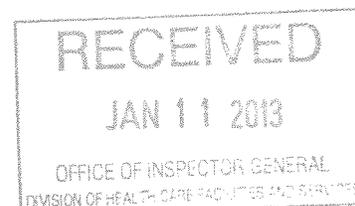
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185435	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1381 CAMPBELL LANE BOWLING GREEN, KY 42104		
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F 309	<p>Continued From page 19</p> <p>12/13/12 at 3:37 PM, revealed she did not know the facility was supposed to have a Hospice contract, or what was included in the contract. The DON revealed that Hospice was a contracted company consisting of a nurse, CNA, doctor, and Social Services that came into a facility, at the request of the family, to act as an extra set of eyes, input and care. However, the DON could not say what services Hospice was providing to the residents. The DON revealed she did not know that Hospice was supposed to have a POC. The DON revealed she had told the Hospice nurse to make sure their care was coordinated when she was visiting Resident #2, on 12/12/12. The DON revealed she was responsible for contracted companies providing care to the residents, and ensuring both parties were following guidelines detailed in the contract.</p> <p>2. Observation of Resident #10, on 12/11/12 at 8:10 AM, revealed Resident #10 was sitting in his/her wheelchair, in the dining room. Resident #10's legs appeared to long for his/her wheelchair, causing his/her legs to bend while sitting in the chair.</p> <p>Observation of Resident #10, on 12/13/12 at 7:54 AM, revealed Resident #10 sitting in his/her wheelchair with legs bent up in the wheelchair. The residents legs appeared too long for the wheelchair. A bolster was noted to be sitting between the legs of Resident #10 keeping the genitals up against his/her body. The resident unable to talk and voice any needs.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 12/13/12 at 2:07 PM, revealed she had been working since June 2012 and had noticed</p>	F 309		



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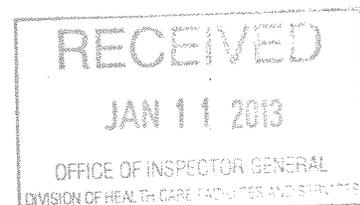
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F 309	<p>Continued From page 20</p> <p>Resident #10's legs had been too long for his/her wheelchair. CNA #4 stated she had not told anyone about Resident #10's legs being overly flexed in the wheelchair.</p> <p>Interview with CNA # 6, on 12/13/12 2:09 PM, revealed he had noticed the residents legs were too long for the wheelchair. CNA #6 stated when he tried to get Resident #10 into his/her wheelchair, he tried to make sure Resident #10 was sitting all the way back in the chair. CNA #6 stated Resident #10's legs appeared too long for the wheelchair and had not told anyone about the wheelchair.</p> <p>Interview with the Physical Therapy Manager (PTA) Manager, on 12/13/12 at 9:06 AM, revealed she was not the one who placed the palmar cushion between the residents legs, they used a profile cushion. Resident #10 experiencing pressure on the genitals could cause some skin issues. The PTA Manager stated she worked with the residents and when the case load was finished, the maintenance and nursing staff were then responsible to adjust the wheelchair or receive the order for therapy to re-evaluate the wheelchair. When staff were unsure on how to fix a wheelchair, she informed them to go to the original plan for the resident. The PTA Manager stated the last time she worked with Resident #10 was in September through November of 2012. The PTA Manager stated a CNA brought to her attention that Resident #10 was sliding and they talked about the Hoyer lift causing the resident to slide. The PTA Manager stated she brought up the sliding in the wheelchair in the morning meeting because it was a nursing issue and as far as she was aware nothing came of it.</p>	F 309		



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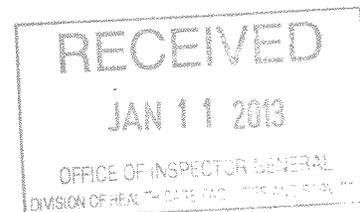
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F 309	Continued From page 21 Interview with the Director of Nursing (DON), on 12/13/12 3:37 PM, revealed if the nurses noticed an issue with a wheelchair, the nurses would fill out a therapy card. If there was a concern with a wheelchair, we would address it in morning meeting and the Maintenance Director would not be involved in the decisions of the wheelchair. The DON stated she could not recall talking about Resident #10's wheelchair in morning meeting.	F 309		
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 (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.	F 441	F 441 A resident surveillance assessment was conducted for resident number # 3 and resident # 5 on 12/18/12 by the Assistant Director of Nursing to assess for any complications related to infection control procedures specifically hand washing with glove changes. No signs and symptoms of infection were noted. A resident surveillance assessment was completed for residents currently in the facility by the Assistant Director of Nursing to assess for any complications related to infection control and hand washing on 1/04/13. No signs or symptoms of infection related to hand washing/glove changing noted.	



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F 441	Continued From page 22 (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 REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to perform proper hand hygiene during skin assessments for two (2) of sixteen (16) sampled residents and six (6) unsampled residents. Resident #3 and #5. The findings include: Record review of the Types of Personal Protective Equipment Policy, dated October 2009, revealed hand washing was to occur after removal of gloves, employees must wash hands and any other potentially contaminated skin area immediately or as soon as feasible, with soap and water. Observation of Resident #3's skin assessment, conducted on 12/12/12 at 3:10 PM, revealed Licensed Practical Nurse (LPN) # 2, assessed Resident #3's buttocks and back legs. Removed gloves and did not wash his/her hands. Donned gloves and assessed Resident #3's peri area, removed gloves and did not wash	F 441	Nursing staff have been re-educated on the policy and procedures for infection prevention specifically hand washing and the washing of hands when changing gloves with return demonstrations observed by the Director of Nursing and the Assistant Director of Nursing on 1/08/13. The Director of Nursing or the Assistant Director of Nursing will observe hand washing/glove changing techniques five times per week for four weeks then three times per week for four weeks then five times per month for one month then quarterly. The Director of Nursing will report findings to the Performance Improvement Committee for three months then quarterly for further recommendations. Completion Date	1/14/13



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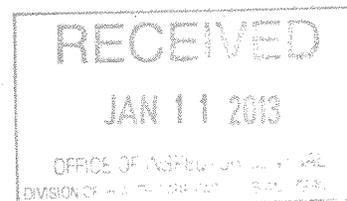
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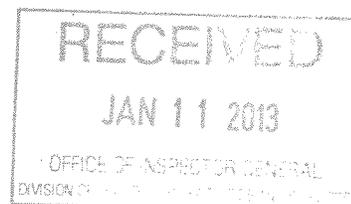
F 441	<p>Continued From page 23</p> <p>hands. Donned gloves again and assessed the remainder of Resident #3's legs and feet.</p> <p>Interview with LPN #2, on 12/12/12 at 4:19 PM, revealed she washed her hands before and after any care was provided. LPN #2 stated she had an in-service on hand hygiene in November of 2012. LPN #2 stated she was not aware to wash her hands after each glove removal and she knew to wash her hands because it prevented the spread of germs.</p> <p>Observation of Resident #5's skin assessment, conducted on 12/12/12 at 3:00 PM, revealed LPN #3 assessed Resident #5's back and buttocks. Removed gloves and did not wash her hands. Donned gloves and assessed the body and the scrotum, removed gloves and did not wash her hands. LPN #3 then donned gloves and assessed the remainder of Resident #3's body.</p> <p>Interview with LPN #3, on 12/12/12 at 3:24 PM, revealed she was aware to wash her hands when entering a room and when finished with care. LPN #3 stated she had removed her gloves twice and she should have washed her hands after each glove removal. LPN #3 further stated they washed their hands to prevent the spread of germs and infection.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 12/13/12 at 3:18 PM, revealed she was the Infection Control Nurse and she had a hand hygiene class recently. The ADON stated she had read the policy and she thought the staff understood the policy was to wash hands between each resident. The ADON stated she was aware staff were to wash their hands after</p>	F 441		
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F 441	Continued From page 24 each glove removal and educated the staff to do so. The ADON stated we wash our hands to prevent the spread infection to residents and staff.	F 441			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 12/11/12. Magnolia village Care and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of fifty seven (57) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Magnolia Village Care and Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 1/10/13

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

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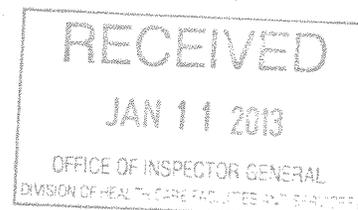
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K 000	Continued From page 1	K 000		
K 025 SS=E	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>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 three (3) of six (6) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty seven (57) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 12/11/12 between 8:00 AM and 9:45 AM, with the Maintenance Director revealed the smoke partition, extending above the ceiling located in the 200, and 300 Halls had</p>	K 025	<p><u>K025</u></p> <p>The Maintenance Director repaired the penetrations located in the 200 and 300 halls with the fire barrier sealant on 12/21/12.</p> <p>The Maintenance Director completed an inspection of all four smoke partitions in the building on 12/21/12. No other repairs were required.</p> <p>The Maintenance Director was re-educated by the Administrator on 1/4/12 on conducting routine inspections of Smoke barriers to ensure they met NFPA standards.</p> <p>The Maintenance Director will conduct smoke partition audits quarterly and the next business day following a vendor repair. The Maintenance Director will report findings to the Performance Improvement Committee quarterly for further recommendations.</p>	1/14/13



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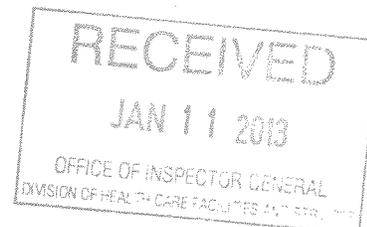
K 025	<p>Continued From page 2</p> <p>penetrations of wires. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke</p> <p>Interview, on 12/11/12 between 8:00 AM and 9:45 AM, with the Maintenance Director revealed he was not aware of the penetrations in the smoke partition.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 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. <p>(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</p> <ol style="list-style-type: none"> 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. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for 	K 025		
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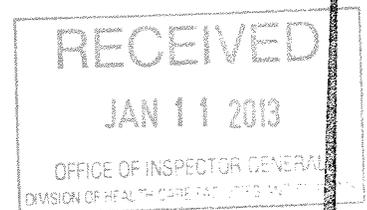
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 K 045 SS=D	<p>Continued From page 3 the specific purpose.</p> <p>NFFA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFFA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty seven (57) on the day of the survey. The facility failed to ensure that means of egress were illuminated continuously and failed to ensure the staff was knowledgeable of the requirement.</p> <p>The findings include:</p> <p>Observation, on 12/11/12 between 8:00 PM and 12:00 PM, with the Maintenance Director revealed the exterior exit located in the back of the Kitchen, and the exit next to the employee lounge only had one light bulb outside to light the egress path.</p> <p>Interview, on 12/11/12 between 8:00 PM and 12:00 PM, with the Maintenance Director revealed he was not aware the exits did not have the required illumination for egress lighting.</p>	K 025 K 045 K045	<p>The Maintenance Director added lighting to the exterior exits located in the back of the kitchen and the employee lounge exit on 12/19/12.</p> <p>The Maintenance Director completed an inspection of exterior exits on 12/17/12, and two additional exits required lighting added according the NFFA standards on 12/19/12 by the Maintenance Director.</p> <p>The Maintenance Director was re-educated by the Administrator on 1/4/12 on conducting routine inspections of the exterior lighting to ensure they met NFFA standards.</p> <p>The Maintenance Director will conduct inspections weekly for four weeks then quarterly and report findings to the Performance Improvement Committee quarterly for further recommendations.</p> <p>Completion Date:</p>	1/14/13



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K 045	Continued From page 4 Reference: NFPA 101 (2000 Edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area	K 045			



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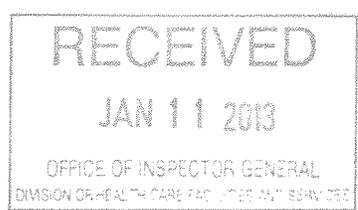
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K 045	Continued From page 5 served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
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 interview and record review of the facility's sprinkler testing record, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is certified	K 062	K062 Fire Guard Systems, Inc replaced both gauges that supplied the entire building on 12/11/12 according to the NFPA standards. Two gauges supply the entire building and both were replaced on 12/11/12. The Maintenance Director placed the expiration date of the gauges on the gauge for 12/11/17 to ensure the gauges are either calibrated or replaced at that time.	



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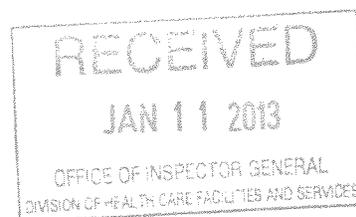
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K 062	<p>Continued From page 6 for sixty (60) beds with a census of fifty seven (57) on the day of the survey. The facility failed to ensure the gauges on the sprinkler risers were calibrated or replaced within the past five (5) years and failed to ensure the staff was knowledgeable of the requirement.</p> <p>The findings Include:</p> <p>Review of the facility's sprinkler testing record, on 12/11/12 at 11:00 AM, with the Maintenance Director revealed the facility did not have documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last five (5) years.</p> <p>Interview, on 12/11/12 at 11:00 AM, with the Maintenance Director revealed he was not aware the sprinkler gauges needed to be replaced or calibrated every five (5) years.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected,</p>	K 062	<p>The Administrator conducted re-education with the Maintenance Director on 1/4/13 regarding the NFPA standards related to the replacement and routine inspection of the sprinkler system.</p> <p>The Maintenance Director will review quarterly and report findings to the Performance Committee for further recommendations.</p> <p>Completion Date:</p>	1/14/13
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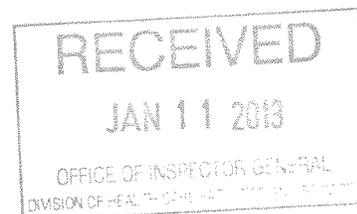
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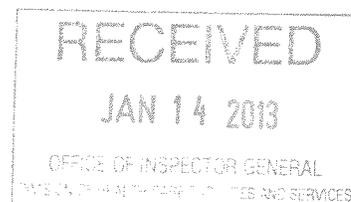
K 062	<p>Continued From page 7 tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1</p>	K 062		
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K 062	Continued From page 8 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and water heater rooms were installed in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty seven (57) on the day of the survey. The findings include: Observation, on 12/11/12 between 8:00 AM and 12:00 PM, with the Maintenance Director revealed vents in the mechanical rooms with gas fired equipment did not vent to the outside, but instead, were open to the attic located in the 100 Hall, 300 Hall, Kitchen, and back hall by the employee lounge. Interview, on 12/11/12 between 11:00 AM and 12:00 PM with the Maintenance Director revealed they were unaware the vents were not to be open to the attic.	K 068 <u>K068</u>	Bowling Green Refrigeration submitted approved bid to repair the vents according to NFPA standards on 1/08/13. The Maintenance Director conducted rounds of the facility on 12/14/12 to find that eight vents needed to be repaired according to the NFPA standards. Bowling Green Refrigeration will also repair additional vents. The Maintenance Director was re-educated by Administrator on 1/4/12 on the standard according to the NFPA related to vents in the mechanical rooms with gas fired equipment. Maintenance Director will review monthly for three months and report findings to Performance Improvement Committee for further recommendations. Completion Date: _____	1/14/13



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K 062 Continued From page 8
Obstruction investigation Maintenance 5 years or as needed Chapter 10

K 062

K 068 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2

K 068 K068

Bowling Green Refrigeration submitted approved bid to repair the vents according to NFPA standards on 1/08/13.

This STANDARD is not met as evidenced by:
Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and water heater rooms were installed in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty seven (57) on the day of the survey.

The Maintenance Director conducted rounds of the facility on 12/14/12 to find that eight vents needed to be repaired according to the NFPA standards. Bowling Green Refrigeration will also repair additional vents.

The findings include:

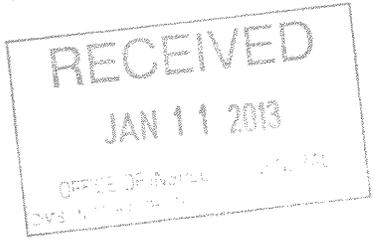
Observation, on 12/11/12 between 8:00 AM and 12:00 PM, with the Maintenance Director revealed vents in the mechanical rooms with gas fired equipment did not vent to the outside, but instead, were open to the attic located in the 100 Hall, 300 Hall, Kitchen, and back hall by the employee lounge.

The Maintenance Director was re-educated by Administrator on 1/4/12 on the standard according to the NFPA related to vents in the mechanical rooms with gas fired equipment.

Ventilation was corrected according to NFPA current standards, Maintenance Director will review monthly for three months and report findings to Performance Improvement Committee for further recommendations..

Interview, on 12/11/12 between 11:00 AM and 12:00 PM with the Maintenance Director revealed they were unaware the vents were not to be open to the attic.

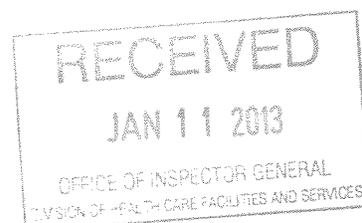
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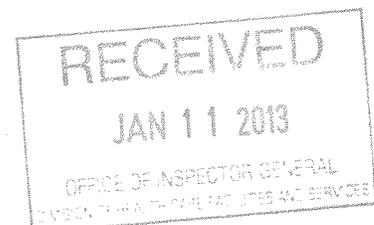
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K 068	Continued From page 9 Reference: NFPA 101 Life Safety Code (2000 edition) Section 19.5 Building Services 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. NFPA 101 LIFE SAFETY CODE STANDARD	K 068		
K 072 SS=E	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of	K 072	<u>K072</u> Linen Carts were removed and stored in a storage room while not in use on 12/13/12. A review was conducted by the Administrator on 12/13/12 of the egress areas to ensure no items were obstructing the egress, no other items were found.	



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K 072	Continued From page 10 six (6) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty seven (57) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments. The findings include: Observations, on 12/11/12 between 8:00 AM and 12:00 PM, with the Maintenance Director revealed the storage of linen carts in the 100, 200, and 300 Halls. Interview, on 12/11/12 between 8:00 AM and 12:00 PM, with the Maintenance Director revealed the items were routinely stored in the 100, 200, and 300 Halls. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	The staff was re-educated by the Assistant Director of Nursing on 1/8/13 on the storage of the linen carts according to the NFPA standards. The Maintenance Director or management staff will conduct audits of exits daily for two weeks then three times per week for two weeks then monthly for two months then quarterly to ensure exits are free of obstructions or impediments and will report finding to the Performance Improvement Committee monthly for three months then quarterly for further recommendations. Completion Date:	1/14/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 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	K 147	<u>K147</u> The microwave in the break room and the refrigerator in the activity office were plugged directly into the wall and the power strip and extension cords were removed by the Administrator on 12/11/12.	



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K 147 Continued From page 11 standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for sixty (60) beds with a census of fifty seven (57) on the day of the survey.

The findings include:

Observations, on 12/11/12 between 8:00 AM and 12:00 PM, with the Maintenance Director revealed a microwave plugged into an extension cord located in the employee break room, and a refrigerator was plugged into a power strip located in the Activities Office.

Interview, on 12/11/12 between 8:00 AM and 12:00 PM, with the Maintenance Director revealed they were aware of the proper use of power strips and extension cords but not aware any had been misused.

Reference: NFPA 101 (2000 Edition)

9.1.2 Electric.
Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.

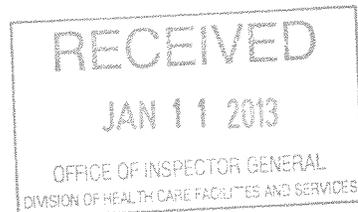
Reference: NFPA 70 400-8
(Extensions Cords) Uses Not Permitted.
Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:
(1) As a substitute for the fixed wiring of a

K 147 A review of the facility was completed by the Maintenance Director on 1/4/13 of all electrical wiring and equipment and there were no findings of misuse.

Staff have been re-educated not to use extension cords and appropriate use of power strips by the Assistant Director of Nursing on 1/8/12.

The Maintenance Director will conduct audits of all electrical wiring and equipment for the use of power strips or extension cords monthly for three months then quarterly and report finding to the Performance Improvement Committee for further recommendations for three months then quarterly.

Completion Date: 1/14/13



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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185435	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2012
NAME OF PROVIDER OR SUPPLIER MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1381 CAMPBELL LANE BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 12 structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>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.</p>	K 147		

