

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

PRINTED: 12/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/07/2016
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF GLASGOW	STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD STREET GLASGOW, KY 42141
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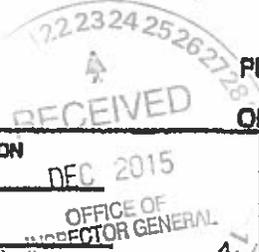
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance on 01/07/16, as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) 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.

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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF GLASGOW			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD STREET GLASGOW, KY 42141	
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F 000	INITIAL COMMENTS	F 000	F00 This plan of correction constitutes Diversicare of Glasgow's credible allegation of compliances for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violation of state and federal statutes, regulations or standard of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.	
F 226 SS=D	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Resident Incident Report and the Abuse Policy, it was determined the facility failed to implement the facility's policy related to reporting an allegation of an injury of unknown origin to the appropriate State agencies. The findings include: Record review revealed the facility admitted Resident #1 on 01/05/15 with diagnoses of Dementia, Alzheimer's Disease, and a history of falling. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/05/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of six (6) indicating the resident was not interviewable. Review of the facility's Abuse and Neglect Policy.	F 226	F226 483.13(c) develop/implement abuse/neglect, etc policies. What corrective action will be accomplished for those residents found to be affected by the deficient practice? Once the center discovered the bruising on Resident #1, the physician and daughter were notified of the event on 11/2/15. Resident #1 was assessed for the injuries including bruising on 11/2/15. No further injury was noted. Injury investigation was then immediately initiated by the Director of Nursing. Investigation of bruising was concluded on 11/3/15 and it was determined that the injury was sustained from resident's watch. The resident had immediate care plan interventions put into place related to preventing further injury from her watch. How will the facility identify other residents having the potential to be affected by the same deficient practice? All other resident's in the center were assessed for injuries including bruises, no other injuries or bruising was noted on all other residents assessed, which was completed on 11/10/15. All center resident's will be assessed weekly utilizing a weekly skin inspection noted from an unknown source will be investigated immediately	

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

S. H.

TITLE

N. H. H.

(X6) DATE

12-23-15

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

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F 226	<p>Continued From page 1 dated 03/01/14, revealed the facility should immediately report to the State agency a violation of mistreatment, neglect, and abuse to include injuries of an unknown source.</p> <p>Review of the facility's Resident Incident Report for Resident #1, dated 11/02/15 at 7:59 AM, revealed the resident's daughter informed the nurse of bilateral bruises to the resident's lower arms. The physician and the resident's daughter were notified of the incident; and the incident was investigated by the facility but they failed to notify the State Survey Agency regarding the injury of unknown origin.</p> <p>Interview with the Director of Nursing (DON), on 12/03/15 at 7:55 AM, revealed Resident #1's injury of unknown origin was not reported to the State Survey Agency because the facility's investigation determined the injury could have been caused by the resident's watch.</p>	F 226	<p>F226 Continued. as per the center's abuse policy by the Administrator and/or DNS. Any injuries after the investigation is completed that are still determined to be source unknown will have notification of the OIG per the center's abuse policy. What measures will be put into place or systematic changes made to ensure the deficient practice will not occur? In-service education was provided by DNS, ADNS, and QA Nurse to all center team members on the Diversicare abuse policy, which included the CMS (Ref: SAC-0509) definition of injury of unknown origin; and reporting alleged violations to the center Administrator and/or Director of Nursing Service immediately beginning 12/21/15 and concluding on 1/8/16. All center newly hired team members will also complete abuse policy training which will be repeated no less than annually. The administrator and Director of Nursing Service have been re-educated on requirements of reporting to the appropriate agencies as per the Diversicare Abuse Policy (3/1/2014), by the Regional Director of Clinical Operations on 12/23/15. The DNS and/or ADNS will be responsible for monitoring the skin inspection reports weekly to ensure there are no unidentified injuries from the unknown source. How will the facility monitor performance to ensure solutions are sustained? To maintain continued compliance the administrator and/or DNS complete the CSM Abuse Prohibition Review. Findings of the review will be reviewed at the center's monthly QAPI meeting, which is attended by the center's Administrator, DNS, Medical Director and other center department leadership team members. These findings will be reviewed monthly for 3 months and then quarterly for 6 months with any additional interventions or suggestions that the QAPI team recommends, to maintain continued compliance. Date of Correction:</p>	1/7/2016	