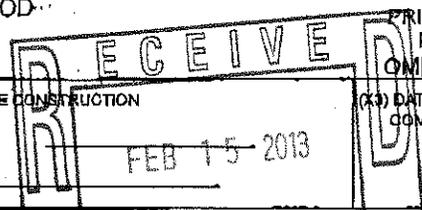


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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/04/2013
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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP+4 220 WESTWOOD ST. GLASGOW, KY 42141
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F 000	INITIAL COMMENTS	F 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This plan is being submitted because it is required by law.	
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a sanitary, orderly, and comfortable interior was maintained for one unsampled resident of five unsampled residents and fifteen sampled residents. A wheelchair seat for Resident E was observed cracked and torn.</p> <p>The findings include:</p> <p>An interview conducted with the Maintenance Director on 01/04/13 at 4:00 PM, revealed the facility did not have a written maintenance policy regarding the maintenance of equipment. According to the Maintenance Director, the facility utilized The Equipment Lifecycle System (TELS), a computerized maintenance and tracking system to identify concerns with resident equipment.</p> <p>Observations conducted during the initial tour on 01/02/13 at 12:15 PM revealed a wheelchair seat for Resident E was cracked and torn.</p> <p>A review of a TELS audit completed by the</p>	F 253	<p>The wheelchair seat for resident E was fixed on 1/15/13 by the maintenance director.</p> <p>ADON checked all wheelchairs and geri-chairs on 1/15/13 for any cracked, torn or broken parts. Any identified parts were ordered by maintenance director on 1/23/13. These will be placed on wheelchairs/geri-chairs when they are received.</p> <p>Administrator, Maintenance Director and Director of Housekeeping director to to complete environmental audit by 2/17/13 to ensure a sanitary, orderly and comfortable environment is maintained. Any issue noted will be addressed.</p> <p>On 2/8/13 maintenance director will re-educate staff on the procedure for reporting issues that include</p>	2-18-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2-15-13
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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 253	Continued From page 1 Maintenance Director to identify concerns with resident wheelchairs and geri-chairs revealed no evidence the concerns with Resident E's wheelchair had been identified.	F 253	cracked, broken or torn parts on wheelchairs or geri-chairs.	
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS  A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure a comprehensive assessment was conducted no less than once every 12 months for one of fifteen sampled residents. Record review conducted on 01/03/13, revealed an annual comprehensive assessment had not been completed for Resident #1 in November 2012 as required to ensure the assessment was completed no less than every 12 months.  The findings include:  A review of the facility's Minimum Data Set Policy entitled Comprehensive Assessments, dated April 2012, revealed Comprehensive Assessments were required to be completed upon admission,	F 276	DON will add a memo to care tracker for all nursing staff related to this process on 2/8/13.  Effective 2/17/13 environmental audits to be completed no less than monthly by safety committee. Safety committee members will be educated by Administrator in regards to completing environmental audit by 2/17/13 including reporting issues to maintenance regarding repairs, housekeeping and equipment. Environmental audits to be reviewed by Administrator upon completion.  The safety committee to check all wheelchairs/geri-chairs and complete environmental rounds no less than monthly to ensure a sanitary, orderly and comfortable interior is maintained. Safety Committee will report findings to Administrator monthly who will report to QA Committee quarterly for one year.	2/18-13

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F 275	Continued From page 2 annually, or if a significant change of condition occurred.  A review of the medical record for Resident #1 revealed a comprehensive assessment with an assessment reference date of 11/29/11. However, there was no evidence a comprehensive assessment had been completed for Resident #1 in 2012.  An interview conducted with the Minimum Data Set (MDS) Coordinator on 01/03/13 at 10:00 AM, revealed the MDS Coordinator had not completed a comprehensive assessment for Resident #1 as required. The MDS Coordinator stated she had not recognized the annual comprehensive assessment was due and had failed to complete the assessment. Further interview revealed an annual assessment for Resident #1 should have been completed in November 2012 instead of a quarterly assessment.  An interview conducted with the Director of Nursing (DON) on 01/04/13 at 10:40 AM, revealed the MDS Coordinator put the assessment on a schedule and completed the scheduled assessments. However, according to the DON, she did not follow up to make sure assessments were completed as scheduled.	F 276	MDS Coordinator completed an annual assesment on Resident #1 on 1/3/13. The residents care plan was reviewed and revised as indicated.  The MDS Coordinator completed an audit on 1/3/13 to determine if any other assessments were out had been missed. No other assessments had been missed.  Corporate consultant discussed with MDS assessments types and timing requirments on 2/1/13 with the MDS Coordinator. The MDS Coordinator is to use a scheduler to assist in tracking date and type of assessment.  Corporate consultant will review the sceduler and run an assessment completion report montly for 3 months then quarterly to ensure assessments are being completed as required. Corporate consultant will report findings to the Administrator who will review the findings with the QA Committee quarterly for no less than one year.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		2-18-13	

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F 280	<p>Continued From page 3</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the comprehensive plan of care was reviewed and revised for one of fifteen sampled residents (Resident #2). The facility's dietitian and Resident #2's physician made recommendations/changes to Resident #2's diet; however, the facility failed to review and revise the resident's comprehensive plan of care to reflect the changes.</p> <p>The findings include:</p> <p>An interview with the Director of Nursing (DON) on 01/04/13 at 4:00 PM revealed there was no policy regarding reviewing or revising the comprehensive care plans.</p>	F 280	<p>The care plan for resident #2 was updated by the dietary manager on 1/10/13 to reflect the dietary supplement to be provided as ordered.</p> <p>Dietary manager reviewed all care plans to ensure the use of dietary supplements were included. This was completed on 1/10/13. Care plan team to review all care plans by 2/15/13 to ensure care plans are accurate and reflective of services currently being provided to residents.</p> <p>Dietary manager to review all MD orders daily for any order for any dietary supplement and will be responsible for updating the care plan to include the dietary supplement per order. Dietary manager will also review all recommendations by Consultant Dietician to ensure all recommendations are communicated to physicians and orders obtained for dietary supplements as indicated.</p>	2-18-13

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F 280	<p>Continued From page 4</p> <p>A review of the Comprehensive Plan of Care dated 03/20/12 for Resident #2 revealed the resident was at risk nutritionally, and staff had noted the resident was on a fortified, no added salt diet. Resident #2 was not to receive nuts, kernels, or seeds and no dairy or ice cream was to be served with the resident's lunch and supper meals. In addition, according to the care plan, staff was to provide Resident #2 with Enlive (a nutritional supplement), twice daily, when they administered medications to the resident.</p> <p>A review of the Dietician's Nutrition Services Recommendations, dated 05/16/12, revealed Resident #2's weight had decreased and the dietician recommended Enlive to be added to the resident's lunch and supper meal trays. However, staff failed to update the resident's care plan to reflect the dietician's recommendations for the addition of the nutritional supplement to the resident's meals.</p> <p>On 09/27/12, Resident #2's physician ordered for Resident #2 to receive a fortified, no added salt diet with no dairy products, nuts, seeds, or kernels. In addition, the physician requested Enlive to be added to the resident's supper and lunch meals. However, staff also failed to update the resident's care plan at that time to reflect the physician's orders for the addition of the Enlive to the resident's meals.</p> <p>Physician's orders dated 01/01/13 through 01/31/13 revealed Resident #2 was to receive a fortified, no added salt diet, no seeds or kernels, and no dairy products related to the resident's lactose intolerance. In addition, the physician again requested staff to provide the resident with</p>	F 280	<p>DON to review 25% of care plans monthly for 4 months then 25% quarterly to ensure that all dietary supplements are included on the care plans and that the care plan is reflective of the services being provided to residents.</p> <p>Results of these reviews will be reported to the facility QA Committee no less quarterly for one year.</p>	2/18/13

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F 280	Continued From page 5 a carton of Enlive with his/her lunch and supper meals. However, facility staff failed to update the resident's care plan to reflect the physician's diet order.  Observation of the lunch meal on 01/03/13 revealed Resident #2 received ham, beans, vegetables, and a peach dessert. However, observations revealed staff failed to provide the resident with Enlive with the meal.  Interview with the Director of Nursing (DON) on 01/04/13 at 4:30 PM revealed the Dietary Manager (DM) updated the dietary care plans related to any dietary recommendations or dietary changes by the physician.  Interview with the Dietary Manager (DM) on 01/04/13 at 4:45 PM revealed the DM had received the dietitian's recommendations and physician's orders related to the addition of the Enlive to Resident #2's meals at lunch and supper. The DM stated when she received the copy of the diet orders she updated care plans and resident tray cards for any diet changes. However, the DM stated she had failed to update Resident #2's care plan in accordance with the physician's order and the dietitian's recommendations.	F 280	Resident #2 received Enlive with medication pass on 1-3-13 so supplement was not missed. Dietary Manager and DON on 1-4-13 Enlive added to resident 2 tray at lunch and dinner.  Dietary Manager reviewed all resident care plans and dietary tray cards to ensure the use of dietary supplements were included. This was completed on 1/10/13.  DON, MDS Coordinator, ADON, Dietary Manager, Restorative nurse, and Social Services reviewed all nurse aide care plans, assignments sheets and comprehensive care plans on 2/15/13 to ensure they are reflective of services being provided. The comprehensive care plan, nurse aide care plan and assignment sheet were compared for consistency. Residents observed to ensure services identified were provided.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced	F 281	On 1/14/13 Dietary manager re-educated dietary staff on following the tray cards, providing dietary supplements per the tray card and ensuring adaptive equipment was provided to residents.	2-18-13

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F 281	<p>Continued From page 6</p> <p>by: Based on observation, interview, and record review it was determined the facility failed to ensure services provided met professional standards of quality for one of fifteen sampled residents (Resident #2). Resident #2 had physician's orders for Enlive (nutritional supplement) to be given at lunch and supper meals; however, observation of the lunch meal on 01/03/13 revealed staff failed to ensure Resident #2 received the Enlive supplement as ordered.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 01/04/13 at 4:30 PM revealed the facility did not have a specific policy related to physician's orders, but stated staff was expected to ensure orders were followed.</p> <p>A review of Resident #2's physician's orders dated 09/27/12 revealed Resident #2's physician ordered for the resident to receive Enlive (a nutritional supplement) with the resident's supper and lunch meals. In addition, a review of physician's orders for 01/01/13 through 01/31/13 also revealed Resident #2 was to receive a carton of Enlive with his/her lunch and supper meals.</p> <p>Observation of the lunch meal on 01/13/13 revealed Resident #2 did not receive the Enlive supplement with the lunch tray as ordered.</p> <p>Due to Resident #2's cognitive status, an interview was not conducted.</p> <p>An interview with Certified Nursing Assistant</p>	F 281	<p>It is the responsibility of the cook to ensure the tray cards are followed according to orders.</p> <p>Beginning on 2/15/13 continuing thru 2/17/13 nursing staff re-educated on following resident care plans and ensuring all services provided as indicated to resident. Licensed staff re-educated on responsibility to update care plans when resident needs change. This was provided b DON and ADON.</p> <p>The DON or ADON to review 25% of comprehensive care plan, nurse aide care plan, assignment sheet and medical record monthly to ensure they are reflective of services being provided. These same 25% will be observed to ensure services are being provided as identified.</p> <p>Dietary Manager, Administrator or cook to audit no less than 25% of resident trays at each meal daily for 1 week, then 25% of resident trays at one meal per day for 2 weeks then 25% of resident trays for one meal 3 times per week for 2 weeks then will audit 25% of resident trays for one meal weekly to ensure the tray cards are followed.</p>	2/13

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F 281	Continued From page 7 (CNA) #3 on 01/03/13 at 1:15 PM revealed the Enlive supplement had not been provided on Resident #2's lunch tray and, as a result, the resident did not receive the supplement.  An interview with Registered Nurse (RN) #1 on 01/03/13 at 1:30 PM revealed the Enlive supplement was on the Medication Administration Record (MAR) to be given at 8:00 AM and 8:00 PM. RN #1 was unaware the Enlive was ordered to be provided at the resident's lunch and supper meals.  An interview with the Dietary Manager (DM) on 01/03/13 at 2:30 PM revealed Resident #2 should have received the Enlive supplement at the lunch meal as ordered. The DM did not know why the supplement was not on the lunch tray.  An interview with Kitchen Staff Member #1 on 01/03/13 at 2:40 PM revealed the Enlive supplement was not put on the lunch tray as ordered. The kitchen staff member stated, "I overlooked the supplement I guess."	F 281	Dietary Manager to review tray cards weekly for 4 weeks to ensure they are accurate and supplements and adaptive equipment are on the tray card.  These audits will then be completed quarterly to ensure sustained compliance. All audits and reviews will be reported to the facility QA Committee no less than quarterly for one year.	2-18-13
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 282		

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F 282	<p>Continued From page 8</p> <p>and facility policy review, the facility failed to ensure services were provided in accordance with the plan of care for two of fifteen sampled residents (Residents #6 and #13). Resident #6's care plan directed staff to provide the resident with a "weighted" cup with a lid for meals related to the resident's chewing and swallowing problems; however, observation of the breakfast meal on 01/03/13 revealed facility staff failed to provide the resident with a weighted cup with lid. Resident #13's care plan directed staff to utilize a "nosey cup" (a cup designed to assist residents with difficulty in swallowing) with meals related to the resident's chewing/swallowing problems; however, observations during the lunch meal on 01/04/13 revealed a "nosey cup" was not provided for all liquids on the resident's tray.</p> <p>The findings include:</p> <p>A review of the facility Self Feeding Ability and Self Help Devices Policy (no date) revealed self-help feeding devices would be ordered by the Occupational Therapist (OT) and would be provided for the resident at each meal. The policy further noted the self-help feeding utensils would be documented in the resident's care plan.</p> <p>1. Review of the medical record revealed the facility admitted Resident #6 on 09/20/05 with diagnoses to include Stroke, Paralysis, Diabetes, and Schizophrenia.</p> <p>A review of the Comprehensive Care plan dated 08/10/11 revealed the facility assessed Resident #6 to require a mechanically altered diet due to chewing and swallowing problems. The care plan interventions also included to provide the resident</p>	F 282	<p>The weighted cup for resident #6 was discharged on 1/15/13 and changed to a Kennedy cup with Straw. This change was noted on the care plan 1/15/13. Dietary Manager provided a 2<sup>nd</sup> nosey cup to Resident #13 on 1/4/13</p> <p>Dietary Manager reviewed all resident care plans and dietary tray cards to ensure the use of adaptive equipment was included. This was completed on 1/10/13.</p> <p>DON, MDS Coordinator, ADON, Dietary Manager, Restorative nurse, and Social Services reviewed all nurse aide care plans, assignments sheets and comprehensive care plans on 2/15/13 to ensure they are reflective of services being provided. The comprehensive care plan, nurse aide care plan and assignment sheet were compared for consistency. Residents observed to ensure services identified were provided.</p> <p>On 1/14/13 Dietary manager re-educated dietary staff on following the tray cards, providing dietary supplements per the tray card and ensuring adaptive equipment was provided to residents.</p>	2/18-13

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F 282	<p>Continued From page 9</p> <p>with a weighted cup with a lid at mealtimes.</p> <p>Observation of the breakfast meal on 01/03/13 at 9:00 AM revealed Resident #6 to be seated in a wheelchair in the restorative dining room. Facility staff provided the resident with a ground meal, carbohydrate controlled diet with no added salt. The resident received oatmeal, skim milk, cranberry juice, and water in a clear cup with a screw-on lid and a straw in the lid. Resident #6 fed his/her self and drank milk from the carton without difficulty; however, the resident spilled the cranberry juice when trying to drink from the glass, and did not drink the water that was provided in the clear cup with a screw-on lid and a straw in the lid. A review of the resident's meal card also revealed the resident was on precautions for feeding and swallowing and was to receive liquids from a weighted cup with a lid. Staff was observed to assist Resident #6 during the meal service; however, staff failed to serve the resident beverages in a weighted cup with a lid.</p> <p>Resident #6 was unable to be interviewed related to his/her cognitive impairment.</p> <p>Interview with CNA #2 on 01/03/13 at 9:45 AM revealed Resident #6 drank from a clear plastic cup with a straw and did not know why only one cup came with the meal tray. CNA #2 said the clear cup with a straw was what Resident #6 always got and did not know of Resident #6 receiving a weighted cup.</p> <p>Interview with the kitchen staff on 01/03/13 at 2:40 PM revealed Resident #6 was provided a clear plastic cup with a lid and straw, and was not</p>	F 282	<p>It is the responsibility of the cook to ensure the tray cards are followed.</p> <p>Beginning on 2/15/13 continuing thru 2/17/12 nursing staff re-educated on following resident care plans and ensuring all services provided as indicated to resident. Licensed staff re-educated on responsibility to update care plans when resident needs change. This was provided b DON and ADON.</p> <p>Dietary Manager, Administrator or cook to audit no less than 25% of resident trays at each meal daily for 1 week, then 25% of resident trays at one meal per day for 2 weeks then 25% of resident trays for one meal 3 times per week for 2 weeks then will audit 25% of resident trays for one meal weekly to ensure the tray cards are followed.</p> <p>Dietary Manager to review tray cards weekly for 4 weeks to ensure they are accurate and supplements and adaptive equipment are on the tray card. These audits will then be completed quarterly to ensure sustained compliance.</p>	2/18/13
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185340	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/04/2013
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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141
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F 282	<p>Continued From page 10</p> <p>aware, the resident was to receive liquids in a weighted cup with a lid.</p> <p>Interview with the Dietary Manager on 01/03/13 at 2:30 PM revealed Resident #8 was to be served liquids in a clear cup with a screw-on lid and straw at mealtimes. The DM further stated when a special cup was ordered, only one cup was sent for each resident and the staff was to rinse the cup out between serving the liquids provided at mealtimes.</p> <p>Interview with the Speech Therapist (ST) on 01/04/13 at 9:15 AM revealed Resident #6 was to have a weighted cup with a lid as ordered and staff failed to provide the resident a weighted cup as identified in the plan of care.</p> <p>2. Review of the medical record revealed the facility admitted Resident #13 on 11/17/09 with diagnoses to include Dementia, Congestive Heart Failure, Parkinsonism, and Diabetes Mellitus.</p> <p>A review of the comprehensive care plan dated 07/18/12 revealed the facility assessed the resident to require a mechanically altered diet due to chewing and swallowing problems. The care plan interventions included to provide food in a divided plate, provide a "nosey cup" with meals, and a pureed diet with nectar-thickened liquids.</p> <p>Resident #13 was observed on 01/04/13, at 11:55 AM to be sitting in a wheelchair in the restorative dining room. Staff was observed to arrange the food items/utensils on the resident's tray. The tray was observed to consist of pureed foods in a divided plate, a glass of nectar-thickened milk in a "nosey cup," and nectar-thickened water in a</p>	F 282	<p>The DON or ADON to review 25% of comprehensive care plan, nurse aide care plan, assignment sheet and medical record monthly to ensure they are reflective of services being provided.</p> <p>These same 25% will be observed to ensure services are being provided as identified.</p> <p>All audits and reviews will be reported to the facility QA Committee no less than quarterly for one year</p>	D-18-13
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F 282	<p>Continued From page 11</p> <p>regular drinking glass. The resident was observed to drink the water from the regular glass without difficulty. A review of the resident's meal tray card revealed staff was directed to allow the resident to feed him/herself with supervision and to offer verbal cues as needed; to encourage the resident to alternate bites of foods with sips of liquids; and to provide liquids in a "nosey cup." Staff was observed to follow the appropriate feeding precautions/techniques during the lunch meal; however, staff failed to ensure the resident's liquids were provided in a "nosey cup."</p> <p>An interview conducted with Certified Nurse Aide (CNA) #9 on 01/04/13, at 12:10 PM, revealed the CNA was familiar with the diet orders and self-help feeding devices required for Resident #13. The CNA stated the tray sent from the kitchen contained only one "nosey cup" and staff would allow the resident to drink that liquid first, and then rinse the "nosey cup" and pour in the second liquid for the resident to drink. The CNA stated the resident drank the water before she could intervene during the 01/04/13 lunch meal.</p> <p>Interview with the Dietary Aide on 01/04/13, at 2:10 PM, revealed the thickened liquids were pre-packaged and were placed on the tray with the "nosey cup." The Dietary Aide stated she poured the milk into the "nosey cup" and assumed staff was to rinse the "nosey cup" after the first liquid was consumed and then pour the second liquid into the cup. The Dietary Aide verified extra "nosey cups" were in the kitchen storage area. However, the Dietary Aide stated she had not thought about providing a second "nosey cup" for the resident.</p>	F 282		

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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
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F 282	Continued From page 12 Interview with the Dietary Manager (DM) on 01/04/13, at 2:00 PM, revealed facility staff was to rinse the "nosey cup" after the first liquid was consumed and then pour the second liquid into the "nosey cup." The DM stated she only received one cup per resident when the resident had been assessed to need a "nosey cup." The DM stated she wasn't sure if extra "nosey cups" were available for resident use, and had not requested additional cups for the resident.  Interview conducted with the Speech Therapist (ST) on 01/04/13, at 12:15 PM, revealed the resident had been assessed to require the use of the "nosey cup" to assist with self-eating. The ST stated the resident could do "ok" with a regular glass, but did better with the "nosey cup."	F 282	Upon identification the water to the beauty shop was turned off by the Maintenance Director and on 1/10/13 a plumbing contractor fixed the water.  On 1/31/13 the Maintenance Director checked water temps in all resident rooms, bathrooms, common areas to ensure water temps were within the accepted range  Administrator, Maintenance Director and Director of Housekeeping director to complete environmental audit by 2/17/13 to ensure a sanitary, orderly and comfortable environment is maintained and remains as free of accident hazard as possible. Any issue noted will be addressed.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the resident environment remained as free of accident hazards as is possible. Hot water temperatures were observed to be 160 degrees Fahrenheit at a sink in the resident beauty salon.	F 323	Water temps are monitored in the TELS system which is a computer program used by the maintenance department to schedule and monitor audits within the facility. The beauty shop has been added to the water temp monitoring in TELS. And will be monitored daily for one week, then weekly for one month then added to the routine schedule.	2-18-13

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F 323	<p>Continued From page 13</p> <p>The findings include:</p> <p>An Interview conducted with the Maintenance Director revealed the facility used The Equipment Lifecycle System (TELS), a computerized maintenance system to monitor the water temperatures in the resident rooms and laundry. According to the Maintenance Director, the hot water temperature in the resident rooms and shower rooms was required to be 100 to 110 degrees Fahrenheit.</p> <p>Observations conducted on 01/04/13 at 9:15 AM, revealed the hot water temperature in the resident beauty salon was 160 degrees Fahrenheit.</p> <p>An interview conducted on 01/04/13 at 10:40 AM, with the licensed beautician who came to the facility to provide services to the residents revealed the beautician adjusted the water temperature to provide comfort to the residents and to prevent potential burns from the water. The beautician stated she monitored the temperature of the water when in use for the residents by holding her finger in the water stream during use to ensure the water temperature was not too hot and was comfortable. Additional interview with the beautician revealed she was not aware of any specific water temperature requirements for the salon and was aware to contact Maintenance of any concerns with the water. Further Interview revealed the beautician was not aware of any resident being burned by the water in the salon sink.</p>	F 323	<p>Effective 2/17/13 environmental audits to be completed no less than monthly by safety committee.</p> <p>Safety committee members will be educated by Administrator in regards to completing environmental audit by 2/17/13 including reporting issues to maintenance regarding repairs, housekeeping and equipment. Environmental audits to be reviewed by Administrator upon completion.</p> <p>As part of the QA program for the facility the TELS monitoring is reported no less than quarterly.</p> <p>The water temp in the beauty shop will be reported for one year to ensure sustained compliance</p> <p>The safety committee to check all wheelchairs/geri-chairs and complete environmental rounds no less than monthly to ensure a sanitary, orderly and comfortable interior is maintained. Safety Committee will report findings to Administrator monthly who will report to QA Committee quarterly for one year.</p>	2-18-13
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F 323	Continued From page 14 An Interview conducted with the Maintenance Director on 01/04/13 at 9:15 AM, revealed the Maintenance Director was aware the water in the resident salon sink was 160 degrees Fahrenheit because the sink in the resident salon was on the same hot water plumbing as the resident laundry. The Maintenance Director stated he didn't think the water temperature was a concern because the resident salon was kept locked and the sink was utilized by a beautician that came to the facility.	F 323	Effective 2/17/13 environmental audits to be completed no less than monthly by safety committee.  Safety committee members will be educated by Administrator in regards to completing environmental audit by 2/17/13 including reporting issues to maintenance regarding repairs, housekeeping and equipment. Environmental audits to be reviewed by Administrator upon completion.  As part of the QA program for the facility the TELS monitoring is reported no less than quarterly.  The water temp in the beauty shop will be reported for one year to ensure sustained compliance  The safety committee to check all wheelchairs/geri-chairs and complete environmental rounds no less than monthly to ensure a sanitary, orderly and comfortable interior is maintained. Safety Committee will report findings to Administrator monthly who will report to QA Committee quarterly for one year.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the medication error rate was not, and did not exceed, five percent. Observation of the medication pass revealed staff failed to administer 6 of 44 medications in accordance with physician's orders and, as a result, the medication error rate was determined to be 13.6 percent. Residents B and C had orders for medications to be administered with food and the medications were not administered with food as ordered. Staff attempted to administer Resident D's Dilantin (anticonvulsant) at the wrong prescribed time. Resident B had an Aggrenox capsule and Prilosec capsule that were omitted, and staff failed to obtain the resident's pulse rate prior to administration of Metoprolol	F 332		2/18/13

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F 332	<p>Continued From page 15 (antihypertensive) as prescribed.</p> <p>The findings include:</p> <p>A review of the facility's Medication Administration policy (no date) revealed a "triple check" was to be conducted during the medication pass to ensure the "5 Rights" (patient, drug, dose, time, and route) were observed. The "triple check" consisted of: (1) check the medication when it is pulled from the Medication Administration Record (MAR); (2) check the medication against the MAR; and (3) check the medication again when replacing the medicine in the medicine cart. The policy noted if medication was ordered to be given with food, the medication was to be given with a snack or a meal. In addition, the policy directed staff to make any "vital assessment" as required by the medication.</p> <p>1. A review of Resident C's medical record revealed the resident's physician had prescribed for the resident to receive 100 mg of Metformin ER (anti-diabetic) twice a day, with breakfast and supper.</p> <p>Observation of the medication administration on 01/03/13 at 8:15 AM Eastern Standard Time (EST) revealed Resident C received 100 mg of Metformin ER (anti-diabetic), without food as ordered.</p> <p>Observation of the breakfast service revealed the breakfast trays arrived on the floor at 9:16 AM (EST) and were delivered by 9:25 AM (EST). Resident C received the breakfast tray at 9:25 AM (EST), one hour and ten minutes after receiving the dose of Metformin ER.</p>	F 332	<p>The medication administration time for Resident C's Metformin was changed to correspond with breakfast and supper. This was done on 1/31/13 by DON. Resident D received the Dilantin at 8:00pm as ordered on 1-4-13. CMT #1 re-educated by DON on 1/31/13 regarding following the MAR and Resident B was given the second Omeprazole, was given the Aggrenox. Resident did not have any effects of receiving the Rivastigmine without food.</p> <p>DON re-educated all staff members administering medications on 1/31/13 regarding checking the MAR prior to administering medications, on making sure to administer medications with meals if required and on checking pulse and B/P prior to administering medication for which it is required</p> <p>Pharmacy Consultant to provide in-service to all staff that administer medication on 2-5-13 on med pass procedures.</p>	2-18-13
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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
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F 332	<p>Continued From page 16</p> <p>2. A review of the January 2013 physician's orders for Resident D revealed an order for 300 milligrams (mg) of Dilantin (a medication used to treat seizure disorders) to be administered to the resident at 8:00 PM.</p> <p>Observations of medication administration for Resident D conducted on 01/04/13 at 8:40 AM, revealed Licensed Practical Nurse (LPN) #4 reviewed the resident's medication administration record (MAR), prepared a 300 mg dose of Dilantin, and attempted to administer the medication to Resident D. The surveyor intervened to prevent the LPN from administering the medication to the resident at 8:40 AM instead of at 8:00 PM as prescribed by the physician.</p> <p>An interview conducted with LPN #4 on 01/04/13 at 8:55 AM revealed LPN #4 had misread the MAR and did not realize the medication was to be administered at 8:00 PM.</p> <p>3. A review of the December 2012 physician's orders for Resident B revealed the following medications were prescribed to be administered for the resident: Metoprolol (beta blocker) 25 mg twice a day; Omeprazole (antacid) 20 mg, 2 capsules once a day; Rivastigmine (anti-Parkinsonism/anti-Alzheimer's) 6 mg, twice a day with food; and Aggrenox (stroke reduction) twice a day. The physician's orders also directed staff not to administer the resident's Metoprolol if the resident's heart rate was below 60 beats per minute.</p> <p>During the medication administration pass observed on 01/03/13, at 8:40 AM, the Certified</p>	F 332	<p>This information will then be presented by the DON monthly for 3 months and then annually. All newly hired staff responsible for medication administration will be educated during orientation</p> <p>The Pharmacy Consultant and Administrative nurses to observe each staff member responsible for administering medications within the month then no less than quarterly for 3 quarters to ensure compliance with timing, dosing and monitoring of medications. After the 3 quarters each staff responsible for administering medications will be observed annually. Re-education will occur with any noted deficient practice at the time it is noted. Med pass observations will be reported to the facility QA Committee no less than quarterly for one year</p>	2-18-13

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F 332	<p>Continued From page 17</p> <p>Medication Technician (CMT) was observe to administer 25 mg of Metoprolol to the resident; however, the CMT failed to obtain the resident's heart rate prior to administering the medication in order to determine if the resident's heart rate was below 60 beats per minute as ordered by the physician. The CMT also administered only one capsule of Omeprazole 20 mg, instead of two as prescribed by the physician; and administered 6 mg of Rivastigmine to Resident B with Juice only. In addition, there was no evidence the CMT administered Aggrenox as prescribed by the physician.</p> <p>Interview with CMT #1 on 01/03/13, at 10:00 AM, revealed the CMT had "overlooked" the Aggrenox and failed to administer the medication as ordered. The CMT stated she only administered one Omeprazole capsule to the resident and failed to check the resident's heart rate prior to administering Metoprolol. In addition, CMT #1 stated she had not reviewed the Medication Administration Record (MAR) to ensure the Rivastigmine was given as ordered with food. CMT #1 stated she had been trained to double-check the MARS and to read the directions carefully.</p> <p>Interview conducted with the Director of Nurses (DON) on 01/04/13, at 1:50 PM, revealed the facility's consulting pharmacist conducted medication pass observations quarterly to monitor for possible medication error. The DON stated no problems had been identified.</p>	F 332		
F 468 SS=D	<p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly</p>	F 468		

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F 488	<p>Continued From page 18 secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure corridors were equipped with firmly secured handrails. Handrails were observed loose on the Oaklawn hallway.</p> <p>The findings include:</p> <p>An interview conducted on 01/04/13 at 4:00 PM, with the Maintenance Director revealed the facility did not have a written maintenance policy regarding the maintenance of equipment (handrails). According to the Maintenance Director, the facility utilized The Equipment Lifecycle System (TELS), a computerized maintenance and tracking system to identify concerns with the resident environment.</p> <p>Environmental observations conducted on 01/02/13 at 12:50 PM, and during an environmental tour conducted with the Maintenance Director on 01/04/13 at 3:45 PM, revealed two loose handrails on the Oaklawn hallway near the resident dining room.</p> <p>A review of a computerized audit tool for the handrails for January 2013 revealed the audit had been completed and no concerns were identified regarding handrails being loose.</p> <p>An interview conducted with the Maintenance Director on 01/04/13 at 4:00 PM, revealed the Maintenance Director made rounds weekly to</p>	F 488	<p>The handrails were secured by the maintenance staff on 1/4/13, when identified</p> <p>Maintenance staff checked all handrails on 1/9/13 to ensure they were not loose.</p> <p>Maintenance Director will check handrails monthly and record the checks in the TELS program</p> <p>All checks recorded in TELS are part of the facility QA program and will be reviewed by the facility QA committee no less than quarterly for one year</p>	2/8-13
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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/04/2013
NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 468	Continued From page 19 Identify concerns. A review of the January 2013 computerized audit revealed no concerns with loose handrails. According to the Maintenance Director the January 2013 audit was completed on 12/31/12 and the Maintenance Director had not identified the hand rails were loose.	F 468		
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT  If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section.  Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on interview and a review of dialysis agreements, the facility failed to ensure one of two agreements with dialysis centers had been signed and dated by the Administrator of the facility and the administrative staff of the dialysis center (Dialysis Center #1). A review of the facility's census and condition information revealed three of the facility's sixty-two residents	F 500		

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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141
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F 500	<p>Continued From page 20</p> <p>received dialysis services. A sample of nineteen residents was selected for review. A review of the nineteen residents selected for review revealed Resident #11 received dialysis services at Dialysis Center #1.</p> <p>The findings include:</p> <p>A review of the facility agreements revealed the facility held agreements with two dialysis centers (Dialysis Centers #1 and # 2) to provide hemodialysis services to residents in the facility. Continued review of the agreements revealed the agreement for Dialysis Center #1 had not been signed and dated by the facility's Administrator or the Administrator of Dialysis Center #1.</p> <p>Based on a review of documentation, Resident #11 received dialysis three times a week at Dialysis Center #1.</p> <p>The facility Administrator stated in interview on 01/04/13 at 10:30 AM that Resident #11 received dialysis at Dialysis Center #1 and acknowledged a new agreement/contract had not been inflated and signed by the facility's Administration and representatives of Dialysis Center #1.</p>	F 500	<p>Administrator signed an agreement with the Dialysis Center on 1-7-13</p> <p>Administrator met with DON to identify any other outside resource being utilized by residents to determine the need for any other agreements. This was completed on 1/31/13</p> <p>Administrator to review all outside resources being used quarterly to ensure agreements are in place.</p> <p>Administrator to audit outside agreements quarterly to ensure they are current and will report on any new agreements to facility QA Committee no less than quarterly.</p>	218-13
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
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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: 1985:</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1985 and upgraded in 2008, with 86 smoke detectors and 3 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1985 and upgraded in 2009.</p> <p>GENERATOR: Type II generator installed in 1987. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 01/03/2013. Glasgow Health and Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-eight (68) beds with a census of sixty-three (63) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator DATE 1-25-13

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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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This plan is being submitted because it is required by law.	
K 018 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dulch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors of resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors.	K 018	The facility has ordered ties from Lowes for the cubicle curtains for all rooms to ensure they do not block the doors from closing. These will be applied once received. The wheelchair in room 137 has been moved. The doors to rooms 5, 12, 136 were repaired on 1/18/13 to ensure they latch properly.  A 100% audit was done on 1/18/13 by the housekeeping supervisor and maintenance director to ensure all facility doors latched according to code.  A 100% aduit was done on 1/18/13 by the housekeeping supervisor and maintenance director to ensure wheelchairs were not blocking doors to resident rooms.	2-17-13

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K 018	<p>Continued From page 2</p> <p>The facility is certified for sixty-eight (68) beds with a census of sixty-three (63) on the day of the survey. The facility failed to ensure resident doors could be closed with a single motion, and doors would properly latch.</p> <p>The findings include:</p> <p>Observations on 01/03/13 between 12:46 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed the corridor doors to the resident rooms throughout the facility were blocked from closing due to privacy curtains blocking the doors. Further observation revealed a wheelchair blocking the door of room #137.</p> <p>Interviews on 01/03/13 between 12:46 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were aware nothing could block the door from closing but were unaware the privacy curtains were blocking the doors.</p> <p>Observations, on 01/03/13 between 12:46 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed the corridor doors to rooms #136, 12, and 5 would not latch properly.</p> <p>Interview, on 01/03/13 between 12:46 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were unaware these doors were not latching properly.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 018	<p>Staff will be inservice on 1/25/13 by the housekeeping supervisor and maintenance director in regards to not blocking resident rooms doors. Once the ties are attached staff will be inserviced on the use of the ties.</p> <p>The facility safety committee will make rounds weekly for one month then monthly to ensure there are no objects to prevent doors from closing</p> <p>These rounds will be recorded in TELs and reviewed by Regional Director of Facilities Management(RDFM) no less than quarterly to ensure rounds are being completed.</p> <p>The safety committee will report any ongoing issues to Administrator who will report to the facility QA Committee for one year.</p> <p style="text-align: right;">2-17-13</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  01/03/2013
NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141		
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K 018	<p>Continued From page 3</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with</p> <p>19.3.6.3.3* Hold-open devices that release when the door is</p>	K 018		

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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
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K 018	Continued From page 4 pushed or pulled shall be permitted.  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-eight (68) beds with a census of sixty-three (63) on the day of the survey. The facility failed to ensure six (6)	K 025		

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K 025	<p>Continued From page 5 smoke barriers were sealed around pipes and wires.</p> <p>The findings include:</p> <p>Observations on 01/03/13 between 12:26 PM and 1:05 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed the smoke partitions, extending above the ceiling located throughout the facility, were penetrated by pipes and wires without proper sealant around the penetrations.</p> <p>Interview, on 01/03/13 between 12:25 PM and 1:05 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were unaware of the penetrations in the smoke barriers.</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"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <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"> <li>1. Be filled with a material capable of maintaining</li> </ol>	K 025	<p>The maintenance director sealed the areas in regards to penetrations in the smoke barriers on 1/25/13</p> <p>A 100% audit of all smoke barriers was conducted by the maintenance director on 1/25/13 to ensure there were no others that had been failed to be sealed.</p> <p>The RDFM will develop a memorandum for the maintenance director (MD) to sign in/out vendors and review their final product prior to contractor departure. This will be in place by 1/31/13. We will add fire/smoke penetration inspection to our TEL's system for review. Maintenance director will make rounds weekly for 4 weeks then monthly to check to see that there are no penetrations in fire walls.</p>	2-17-13

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K 025	Continued From page 6 the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	These rounds will be recorded in the TELs program and reviewed by RDFM no less than quarterly to ensure rounds are being completed. Maintenance director will report any ongoing issues to Administrator who will report on same to the facility QA Committee for one year.	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of seven (7) smoke compartments, thirty-four (34) residents, staff and visitors. The facility is certified for sixty-eight (68) beds with a census of sixty-three (63) on the day of the survey. The facility failed to ensure four (4) sets of cross corridors doors would close properly once the fire alarm released them from the magnetic locks.	K 027		

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K 027	Continued From page 7  The findings include:  Observation, on 01/03/13 between 1:42 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed the cross-corridor doors located next to room # 129 would not close completely when tested. This was due to the doors not having a coordinating device installed on the doors. Further observation revealed the doors on each side of the lobby area and the doors next to the dietary manager's office were the same.  Interview, on 01/03/13 between 1:42 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were unaware the doors needed a coordinating device to ensure the door without the metal strip would always close first.  NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 80 (1999 Edition)  2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027	The astragal to be removed and, "siliconseal" (UL approved) will be added to the space between the doors that will eliminate the overlap issue permanently. This will be completed by 1/31/13.  The maintenance director will review the entire building by 1/31/13 in regards to issues related to doors overlapping.  RDFM to provide education of the NFPA Standards to facility maintenance staff by 1/29/13 and provide a copy of the current standard.  Maintenance director to check all doors weekly for one month then monthly. These checks to be recorded in the TELs program and reviewed by the RDFM no less than quarterly to ensure checks are being completed. Maintenance director will report any ongoing issue to Administrator who will report to the facility QA Committee for one year.	2-17-13

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K 027	Continued From page 8	K 027	The door stop to the medical records office was removed on 1/3/13	
	Reference: NFPA 101 (2000 edition)		The magent to the mechanical room was fixed on 1/10/13	
	8.3.4.1* Doors in smoke barrlers shall close the opening leaving only the minimum clearance necessary for proper operallon and shall be without undercuts, louvers, or grilles.		A closure to the dry storage room was installed on 1/17/13	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 029	A door closure was installed to the HR office on 1/17/13	
	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire exltinguishing system optlon is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bollom of the door are permitted. 19.3.2.1		A door closure was installed on the linen closet on 1/17/13	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was delermned the facility failed to meet the requirements of Protection of Hazards In accordance with NFPA Standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, fifty-eight (58) residents, staff and visitors. The facility is certified for sixty-eight (68) beds with a census of sixty-three (63) on the day of the survey. The facility failed to ensure seven (7) rooms with		The resident in room #104 has changed rooms and the family took her things home.	
			The resident in room #4 had family come to the facility on 1/19/13 and remove the majority of items from her room.	2-17-13

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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 9 hazardous storage had the proper separallon.  The findings include:  Observation, on 01/03/13 between 12:46 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed:  1) The Medical Records office had a door wedge propping the door open. 2) The Mechanical room had a magnet holding the door open. 3) The Dry Storage room for the kitchen did not have a door closer installed and had a vent through the door. 4) The Human Resources office did not have a door closer installed due to the amount of storage in the office. 5) The linen closet did not have a door closer installed and swung open into the corridor. 6) Resident room 4 had a substantial amount of combustibles in the room making the room hazardous. 7) Resident room 104 had a substantial amount of combustibles in the room making the room hazardous.  Any room larger than 50 square feet with substantial combustible material must have a door that resists the passage of smoke and a closing device.  Interview, on 01/03/13 between 12:46 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were aware door wedges were not allowed. Further interview revealed they were not aware	K 029	The facility maintenance director will inspect all facility doors by 1/31/13 to identify any other doors requiring door closures. The social services director will inspect all rooms to determine any other room that is cluttered and has combustible that need to be removed by 1/31/13.  RDFM to provide education on the NFPA Standars to the facility maintenance staff by 1/31/13 and provide a current copy of the standard.  Safety Committee will check all door closures, use of door stops and resident rooms for clutter for weekly for four weeks then monthly. These checks will be recorded on the TELs program and reviewed no less than quarterly by the by the RDFM. The maintenance director will report ongoing issues to the Administrator who will report to the QA Committee for one year.	2/1/13

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K 029	Continued From page 10 the rooms listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.  Reference: NFPA 101 (2000 Edition).  19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ). (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or	K 029		

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K 029  K 066 SS=D	Continued From page 11 field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays at an entrance, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke	K 029  K 066		

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K 066	<p>Continued From page 12</p> <p>compartments, twenty-four (24) residents, staff and visitors. The facility is certified for sixty-eight (68) beds with a census of sixty-three (63) on the day of the survey. The facility failed to ensure ashtrays were provided at one (1) smoking area.</p> <p>The findings include:</p> <p>Observation, on 01/03/13 at 3:08 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed the area at the North Willowbrook exit was being used as a smoking area due to all the cigarette butts on the ground at the drain area. The area did not provide an approved ashtray and is not listed as a smoking area at the facility.</p> <p>Interview, on 01/03/13 at 3:08 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were not aware of the requirements to make an area an approved area for smoking.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where</p>	K 066	<p>Staff were inserviced on 1/24/13 the area outside the Willowbrook exit is not a designated smoking area. Designated smoking areas are defined as the Gazebo and outside the building where staff enter to clock in/out for work.</p> <p>The facility safety committee will monitor the smoking areas weekly for 4 weeks then monthly to ensure staff are smoking in designated smoking areas.</p> <p>The maintenance director will report ongoing issues to the Administrator who will report to the QA Committee for one year.</p>	2/13

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K 068	Continued From page 13 smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 068		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 10.3.2.4	K 076		

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K 076	<p>Continued From page 14</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty-two (22) residents, staff and visitors. The facility is certified for sixty-eight (68) beds with a census of sixty-three (63) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu. ft. was stored 5 feet away from any combustibles and ignition sources located five (5) feet from the floor.</p> <p>The findings include:</p> <p>Observation on 01/03/13 at 2:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed nineteen (19) oxygen tanks in the oxygen storage room. The oxygen tanks were being stored within five (5) feet of combustible items.</p> <p>Interview on 01/03/13 at 2:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were unaware oxygen tanks could not be stored within five (5) feet of combustible materials once the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m<sup>3</sup> (300 ft<sup>3</sup>) but less than 86 m<sup>3</sup> (3000 ft<sup>3</sup>) (a) Storage locations shall be outdoors in an</p>	K 076	<p>The facility installed Kobalt Fire Proof cabinets on 1/21/13 to place combustible material in.</p> <p>A 100% audit of the facility will was done on 1/21/13 by the maintenance director to ensure no other areas have combustible material stored with O2 tanks.</p> <p>Staff will be inserviced on 1/24/13 by the DON in regards to not storing combustible items with O2.</p> <p>The safety committee will audit areas weekly for 4 weeks then montly to ensure combustible materials are not stored with O2 tanks.</p> <p>The results of the safety committee audits will be reviewed quarterly at the QA Committee for one year.</p>	2-7-13

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K 076	Continued From page 15 enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet	K 076		

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K 076 K 144 SS=F	Continued From page 18 4-3.5.2,1(b)14, NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-eight (68) beds with a census of sixty-three (63) on the day of the survey. The facility failed to ensure the generator annunciator was at a regular work station.  The findings include:  Observation, on 01/03/13 at 2:10 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed the annunciation panel for the generator was located in the corridor across from room #133. The area was not a regular work station and was not a regular work station.  Interview, on 01/03/13 at 2:10 PM with the	K 076 K 144		

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K 144	<p>Continued From page 17</p> <p>Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were not aware the generator needed an annunciation panel, at a workstation monitored 24/7, to inform staff of alarm conditions of the emergency power source. Further interview revealed the area was once a nurses station that was monitored,</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended</p>	K 144	<p>The panel is in a regular work area that is occupied by residents. Nurses, nurse aides and housekeeping staff provide services in that area 24 hours a day. Staff was instructed on 1/31/13 regarding the location of the annunciation panel for the generator and the need for the panel to be monitored.</p> <p>The facility is in the process of obtaining bids to to make the nurses station operational by 2/17/13.</p> <p>Staff were instructed on 1/31/13 regarding the location of the annunciation panel for the generator and the needs for the panel to me monitored.</p> <p>This change should correct the deficient area and will not need to be audited or reviewed.</p>	2-7-13
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K 144	Continued From page 18 periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]  Reference: NFPA 110 (1999 Edition).  5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.	K 144		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-eight (68) beds with a census of sixty-three (63) on the day of the	K 147		

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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
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K 147	<p>Continued From page 19 survey. The facility failed electrical panels maintained three (3) feet of clearance around them and power strips were being used properly.</p> <p>The findings include:</p> <p>Observations, on 01/03/13 at 2:20 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed the electrical panels in the Sprinkler Control Valve Room had storage shelves within twelve (12) inches of the electrical panels.</p> <p>Interview, on 01/03/13 at 2:20 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they are aware there could not be storage within three (3) feet of an electrical panel. They were unaware the shelves could not be within three feet of the electrical panels.</p> <p>Observations, on 01/03/13 between 1:42 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed:</p> <ol style="list-style-type: none"> <li>1) A mini nebulizer was plugged into a power strip located in room #10.</li> <li>2) A refrigerator was plugged into a power strip and power strip was plugged into another power strip located in room #12.</li> <li>3) A bed and a refrigerator were plugged into a power strip located in room #16</li> <li>4) A bed was plugged into a power strip located in room # 15.</li> <li>5) A suction machine and a bed were plugged</li> </ol>	K 147	<p>All power strips and extension cords to this equipment(mini nebulizers, air conditioning units, oxygen concentrators, feeding pumps, lift chairs)have been removed and all equipment plugged directly into the wall outlet by 1/31/13. The extension cord from room 116 has been removed.</p> <p>By 1<sup>31</sup>/<del>13</del>/13 the maintenance director will have made rounds to identify other improper use of power strips or extension cords. Quad outlets will be ordered and installed to allow each resident additional outlets.</p> <p>Staff will be inserviced by 1/31/13 by maintenance director regarding the use of power strips. This inservice will be repeated monthly for 3 months. Compliance will be evaluated by review of rounds completed for quality assurance. The DON will review reports of the rounds to determine the need for re-education.</p>	2-17-13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186340	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2013
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K 147	<p>Continued From page 20 into a power strip located in room # 8.</p> <p>6) A mini nebulizer and an air mattress were plugged into a power strip located in room # 7.</p> <p>7) A refrigerator and an air conditioning unit were plugged into a power strip located in the med room on willowbrook.</p> <p>8) An extension cord was plugged in a power strip located in room # 115.</p> <p>9) An oxygen concentrator and a feeder were plugged into a power strip located in room # 114.</p> <p>10) A lift chair was plugged into a power strip located in room # 101.</p> <p>Interview, on 01/03/13 between 1:42 PM and 4:00 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were unaware of what could be plugged into a power strip.</p> <p>Reference: NEPA 99 (1998 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for</p>	K 147	<p>Maintenance director will make rounds daily for one week, weekly for four weeks and monthly thereafter to check all areas of the facility for the improper use of power strips and extension cords. Reports will be submitted to the Administrator upon completion. Administrator will report on rounds to QA Committee for one year.</p>	
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K 147	<p>Continued From page 21</p> <p>equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="2">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th>Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td>1 m (3½ ft)</td> </tr> <tr> <td></td> <td></td> <td>1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated bushings operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall</p>	Nominal Voltage to Ground	Minimum Clear Distance		Condition 1	Condition 2	Condition 3	0-150	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)			1.2 m (4 ft)	K 147	
Nominal Voltage to Ground	Minimum Clear Distance																	
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0-150	900 mm (3 ft)	900 mm (3 ft)																
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K 147	<p>Continued From page 22</p> <p>not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.</p> <p>(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.</p> <p>(c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation.</p> <p>(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 760 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.</p> <p>(3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted</p>	K 147		

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K 147	<p>Continued From page 23</p> <p>to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment.</p> <p>(B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded.</p> <p>(C) Entrance to Working Space.</p> <p>(1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment.</p> <p>(2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met.</p> <p>(a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted.</p> <p>(b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition.</p>	K 147		
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K 147	<p>Continued From page 24</p> <p>(D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.</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		
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