

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

PRINTED: 11/22/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185340</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>11/14/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GLASGOW HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>220 WESTWOOD ST.</b> <b>GLASGOW, KY 42141</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/14/13, as alleged.	{F 000}			

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

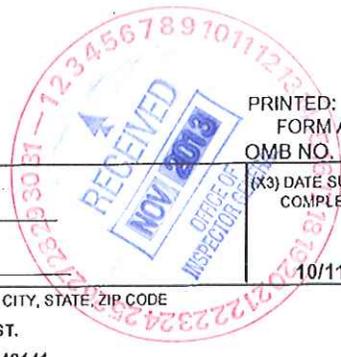
TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 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.  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy and process review, it was determined the facility failed to review and revise the care plan for two (2) of fifteen (#15) sampled residents (Residents #10 and Resident #7).	F 280	Resident # 10 was discharged from the facility on 10/28/13. The care plan for resident #7 was updated on 10/29/13 by the interdisciplinary team to address all resident interventions related to falls.  A 100% audit was completed by the DON on 10/29/13 for all residents with a catheter. The audit will ensure there is a MD order and care plan addressing the catheter. Nursing administration to bring copies of the 24 hour report to morning meeting monitor for any new catheters. Care plans will be updated at this time as well as ensuring a MD order is present.  Education on care planning catheters will be provided to nursing staff/MDS Coordinator by the DON on 10/30/13 to ensure compliance. Staff education will also include writing a MD order timely.	

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(X6) DATE

NHA

11-1-13

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F 280	<p>Continued From page 1</p> <p>Resident #10's care plan was no reviewed and revised related to an urinary catheter and reoccurring Urinary Tract Infections (UTIs) and Resident #7's care was not reviewed and revised related to falls.</p> <p>The findings include:</p> <p>1. An interview with the Director of Nursing (DON,) on 10/11/13 at 2:25 PM, revealed the facility did not have a specific policy for care plans but utilized the "Lippincott Manual of Nursing Practice, Fifth Edition" for all skills and procedures regarding urinary catheters and UTIs.</p> <p>Record review revealed the facility admitted Resident #10 on 10/14/11 with diagnoses which included Alzheimer's Dementia with Behavioral Disturbances and Incontinence.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/10/13, revealed the facility assessed Resident #10 had a urinary catheter, secondary to difficulty voiding and an Inguinal Hernia.</p> <p>Review of the Potential for Infection related to an Indwelling Catheter Care Plan, dated 09/05/13, revealed the care plan was discontinued on 09/24/13; however, an observation of Resident #10, on 10/11/13 at 2:00 PM, revealed a urinary catheter was draining light amber urine to the bedside drainage bag and dignity bag.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/11/13 at 2:07 PM, revealed the resident should have a care plan and she was unsure when the catheter was placed, as there was no order for the catheter and stated the nurse who</p>	F 280	<p>The DON will review the audit form weekly for one month to ensure care plans are updated. She will then review monthly for one year for continued compliance. Any deficient areas will be brought to the QA Committee for review.</p> <p>A 100% audit was completed on 10/29/13 on residents with falls in the last 30 day by nursing administration to ensure any noted interventions have been care planned. The interdisciplinary team will be in serviced by the Regional Nurse Consultant on 11/1/13 regarding the importance of updating care plans with each incident.</p> <p>Incident Reports will be reviewed at morning meetings by the interdisciplinary team and care plans will be updated at this time, if applicable. An audit tool will be developed to track the discussed interventions. The DON will review this audit tool weekly for one month to ensure compliance with care planning the interventions. She will then review the audit tool monthly for one year to ensure compliance. Any deficient practice will be reviewed with the QA Committee quarterly.</p>	11-4-13	

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F 280	<p>Continued From page 2</p> <p>received the order, should have updated the care plan.</p> <p>An interview with the Director of Nursing (DON), on 10/11/13 at 2:25 PM, revealed the licensed nurse, who worked the unit the day the order was received for the catheter and the antibiotic, from the physician, should have reviewed and revised the care plan. The DON stated the urinary catheter was noted on the Treatment Record but there was no mention of the catheter being placed in the physician orders, nursing notes or the care plan, and she stated the care plan should have been completed by the charge nurse or the licensed nurse who received the order.</p> <p>2. A review of the facility policy "Fall Management", dated 01/01/10, revealed staff would review the current plan of care and if necessary revise interventions, or if no plan of care is in place, develop a plan of care to reduce the likelihood the fall would reoccur and minimize the risk of injury related to a fall.</p> <p>Record review revealed the facility admitted Resident #7 on 05/24/12 with diagnoses to include Delirium, Parkinson's Disease, Osteoporosis, Osteoarthritis, Chronic Pain and Vertigo.</p> <p>Review of the MDS assessment, dated 07/24/13, revealed the facility assessed Resident #1's cognition as cognitively intact and to have had one (1) fall with no reported injury since the last review.</p> <p>A review of facility incident reports revealed Resident #7 had eight (8) falls between 05/06/13 through 10/07/13. However, review of the</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>Resident #7's Comprehensive Care Plan, dated 06/06/12, revealed there were no revisions made to the care plan related to falls since 03/20/13.</p> <p>An observation of Resident #7, on 10/08/13 at 12:45 PM, revealed he/she was lying on the bed. Bruising and discoloration were noted around the right eye with a dressing noted above the right eye.</p> <p>An interview with the MD'S Coordinator, on 10/11/13 at 9:20 AM, revealed orders were changed, on the care plan by the floor staff, as new orders are obtained.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 10/11/13 at 10:05 AM, revealed care plans were updated by the interdisciplinary team. The ADON reported that not all interventions are care planned.</p> <p>An interview with the DON, on 10/11/13 at 10/20 AM, revealed staff would not add every intervention to the care plan and this was determined by the interventions placed. The DON stated the staff made appropriate interventions for the resident falls.</p>	F 280	<p>Resident # 10 was discharged from the facility on 10/28/13. The physician was contacted on 10/30/13 for resident #7 in regards to the missed UA.</p> <p>A 100% audit was completed on 10/29/13 by nursing administration for residents with a catheter to ensure those residents have a physician order for the placement of the catheter as well as a care plan.</p> <p>Nursing staff will be inserviced by the DON on 10/30/13 on the importance of documenting the order on the physician orders as well as care planning the order.</p> <p>The medical records custodian will bring a copy of each physician order to the morning meeting to ensure any catheter that was placed has the appropriate order. An audit form was developed on 10/29/13 to track and trend a MD order was obtained for the placement of the catheter as well as a care plan completed by the interdisciplinary team.</p>		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility process review, it was determined the</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>facility failed to provide treatment and services that met professional standards of care for two (2) of fifteen (15) sampled residents (Residents #7 and #10). The facility failed to follow the physician's order to obtain an Urinalysis (U/A) for Resident #7 and to obtain a physicians order for an indwelling urinary catheter for Resident #10.</p> <p>The findings include:</p> <p>An interview with the Director of Nursing (DON,) on 10/11/13 at 2:25 PM, revealed the facility did not have a specific policy for urinary catheters or care plans but utilized the "Lippincott Manual of Nursing Practice, Fifth Edition" for all skills and procedures regarding urinary catheters and U/As.</p> <p>1. Record review revealed the facility admitted Resident #10 on 10/14/11 with diagnoses which included Incontinence and Alzheimer's Dementia.</p> <p>An observation of Resident #10, on 10/11/13 at 2:00 PM, revealed a urinary catheter draining light amber urine to the bedside drainage bag and dignity bag.</p> <p>Review of the physician's orders revealed there was no physician order for the indwelling urinary catheter.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 10/11/13 at 2:07 PM, revealed the resident should have a physician's order for the catheter and he was unsure when the catheter was placed and stated the nurse who received the order, should have written the order, in the resident's chart.</p> <p>An interview with the DON, on 10/11/13 at 2:25</p>	F 281	<p>The DON will review this audit sheet weekly for one month to ensure an order was obtained for a catheter. She will then monitor the audit monthly for one year and report any deficient practice to the QA Committee.</p> <p>A 100% audit was completed on 10/29/13 to ensure all lab orders in the last 30 days had the appropriate follow up.</p> <p>The medical records custodian will be responsible for bringing lab orders to the daily meeting so they can be placed on an audit tool to track they were completed as well track any follow up that is needed.</p> <p>A copy of the audit tool will be monitored weekly by the DON for one month to ensure compliance. This will then be reviewed monthly for one year and any deficient practice will be reviewed with the QA Committee.</p>	11-14-13

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F 281	<p>Continued From page 5</p> <p>PM, revealed the urinary catheter was noted on the Treatment Record but there was no physician order. The DON stated the order should have been completed by the charge nurse or the licensed nurse who received the order.</p> <p>2. Record review revealed the facility admitted Resident #7 on 05/24/12 with diagnosis of Urinary Tract Infection (UTI.)</p> <p>Review of a physician's order, dated 07/03/13, revealed an order for Macrobid (an antibiotic) 100 mg by mouth (PO) for seven (7) days, with an Urinalysis (UA) to be completed in ten (10) days (07/10/13).</p> <p>Review of Resident #7's laboratory results revealed there was no evidence an UA was completed per the physician's order.</p> <p>An interview with LPN #2, on 10/10/13 at 10:10 AM, confirmed an UA was ordered to be completed for Resident #7, after completion of the antibiotic therapy. The LPN stated, when an order was received, a laboratory requisition was generated and the needed test was placed on the calendar, at the desk, to ensure completion.</p> <p>An interview with the DON, on 10/11/13 at 10:45 AM, revealed the licensed staff were to transcribe orders and complete the requisitions for labs and place a note on the calendar, at the desk for the appropriate date. The DON stated the UA should have been obtained, when the physician ordered.</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER  <b>GLASGOW HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>220 WESTWOOD ST.</b> <b>GLASGOW, KY 42141</b>		
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{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/14/13 as alleged.	{K 000}			

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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 (211).</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 10/08/2013. 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		
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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.  The maintenance director sealed the areas in regards to penetrations in the smoke barriers on 10/17/13  A 100% audit of all smoke barriers was conducted by the maintenance director on 10/17/13 to ensure there were no others that had been failed to been sealed.  The maintenance director will add a section to his vendor log for both he and the vendor to initial off all areas have been sealed properly when work in the attic has been completed. Maintenance director will make rounds weekly for 4 weeks then monthly to check to see that there are no penetrations in fire walls.	
K 025 SS=E	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 three (3) of seven (7) smoke compartments, twenty (20) 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 two (2) smoke barriers were sealed around pipes and wires.  The findings include:	K 025		

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K 025	<p>Continued From page 2</p> <p>Observations, on 10/08/13 between 12:25 PM and 1:35 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed the smoke partitions, extending above the ceiling located on both sides of the kitchen in the Grace hall, were penetrated by pipes and wires without proper sealant around the penetrations.</p> <p>Interview, on 10/08/13 between 12:25 PM and 1:35 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed they were unaware of the penetrations in the smoke barriers and they are checked on a monthly basis for penetrations.</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 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>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p>	K 025	<p>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.</p>	11-4-13

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

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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 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  10/08/2013
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 025	Continued From page 3 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	The ignition sources in the O2 room on Oaklawn Hall were covered on 10/9/13. The boxes in the Grace Hall O2 room were removed when brought to staffs attention by the surveyor.  A 100% audit of the facility will was done on 10/14/13 by the maintenance director to ensure no other areas have combustible material stored/ignition sources with O2 tanks.  Staff will be inserviced on 10/30/13 by the Maintenance Director in regards to not storing combustible items with O2.  The safety committee will audit areas weekly for 4 weeks then monthly to ensure combustible materials are not stored with O2 tanks.  The results of the safety committee audits will be reviewed quarterly at the QA Committee for one year.	11-14-13
K 076 SS=E	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, 19.3.2.4  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 two (2) of seven (7) smoke compartments, twenty (20) 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 five (5) feet away from any combustibles and ignition sources were located five (5) feet from the floor.  The findings include:	K 076		

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K 076	<p>Continued From page 4</p> <p>Observation, on 10/08/13 between 12:25 PM and 2:04 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed twenty-one (21) oxygen tanks in the grace hall oxygen room with two (2) cardboard boxes stored in the room with them. Further observation revealed fifteen (15) oxygen tanks in the Oaklawn oxygen room where ignition sources were not located over five (5) feet from the floor.</p> <p>Interview, on 10/08/13 between 12:25 PM and 2:04 PM with the Maintenance Director and Laundry/Housekeeping Supervisor, revealed he was unaware of the boxes stored in the oxygen room and the requirement to have any ignition sources located five (5) feet from the floor.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an 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</p>	K 076		

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K 076	Continued From page 5 Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ 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 4-3.5.2.1(b)14.	K 076		