

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

PRINTED: 09/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/24/2015
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NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the deficiencies were deemed to be corrected on 09/13/15, as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. 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 of guilt by the facility of cited deficiencies or any violation of a regulation or standard of care. Also, we reserve the right to take further action, including any and all legal means necessary, to resolve any dispute about the accuracy of this information.	
F 241 SS=D	<p>Amended</p> <p>A Recertification Survey was conducted on 07/28/15 through 07/30/15 with deficiencies cited at the highest Scope and Severity of a "E".</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to promote dignity and respect for one (1) of fifteen sampled residents (Resident #6). Observation of Resident #6 revealed the resident's catheter bag was not in a dignity bag.</p> <p>The findings include:</p> <p>Review of facility policy titled, "Foley Catheter Care", not dated, revealed staff should secure the catheter properly and ensure the catheter bag was placed in a dignity bag and the dignity bag should not touch the floor.</p> <p>Record review revealed the facility admitted Resident #6 on 05/23/14 with diagnoses which included Quadriplegia and Quadriparesis C1-C4 Complete, Thrombocytopenia, Anxiety State, Depressive Disorder, Chronic Pain, and Urinary tract Infection. Review of the Annual Minimum</p>	F 241	<p>483.15(a)</p> <ol style="list-style-type: none"> 1. Resident #6 had a dignity bag placed over catheter bag on 07/28/2015 by the Director of Nursing. 2. On 07/28/2015 the Director of Nursing verified that every resident who required the use of a catheter had a dignity bag attached to both sides of the bed, and on any chair used for mobility. 3. The Staff Development Nurse will in-service all nursing staff on the Foley Catheter Care policy and procedure by 09/08/2015. 4. The Assistant Director of Nursing or the Director of Nursing will complete a Weekly Dignity Audit for a period of twelve (12) months of all residents requiring the use of catheters to ensure correct placement of tubing, and to ensure dignity bags are in place and used appropriately. 5. After completion, the Director of Nursing will submit the Weekly Dignity Audit to the Administrator. 6. The Administrator will report all findings from the Weekly Dignity Audit to the Quality Assurance Committee monthly for a period of twelve (12) months. 7. The Director of Nursing will be responsible for follow-up and completing the recommendations from the Quality Assurance Committee. <p>(Continued on Page 2)</p>	

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

Yvonne W. Coz

TITLE

NHA

(X6) DATE

09-24-2015

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F 241	Continued From page 1 Data Set (MDS) assessment, dated 05/10/15, revealed the facility assessed Resident #6's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Observation on 07/28/15 at 2:45 PM revealed Resident #8 was assisted to bed by Licensed Practical Nurse (LPN) #8 and Certified Nursing Assistant (CNA) #6. CNA #6 removed the catheter bag from the broda chair and attached it to the bed. The catheter bag was not covered with a dignity bag and residents urine was visible. Interview with CNA #6, on 07/28/15 at 3:18 PM, revealed she did not place the catheter in a dignity bag. Interview with LPN #6, on 07/28/15 at 3:50 PM, revealed Resident #6's catheter bag should have been placed in the dignity bag. Interview with the Assistant Director of Nursing (ADON), on 07/30/15 at 3:05 PM, revealed she expected staff to place catheter bags in a dignity bag. Interview with the Director of Nursing (DON), on 07/30/15 at 3:05 PM, revealed the catheter bag should always be placed in a dignity bag for the residents, and not be allowed to touch the floor.	F 241	(Continued from Page 1) 8. Quality Assurance Committee members are as follows: Dr. Amelia Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherril Likens, LPN, HR/SD	09/13/2015	
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	F 280	483.20(d)(3), 483.10(k)(2) 1. The Director of Nursing updated resident #10's care plan to include the bed alarm and the chair alarm on 07/30/2015. (Continued on Page 3)		

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F 280	<p>Continued From page 2 changes in care and treatment.</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, record review and facility policy review, it was determined the facility failed to review/revise the falls care plans for two (2) of fifteen (15) sampled residents (Resident's #9 and #10). Staff failed to revise the care plan to address Resident #10's behavior of continually getting up without assistance and failed to develop an intervention to address Resident #9's fall on 07/10/15.</p> <p>The findings include: Review of facility policy titled, "Fall Assessment Protocol", last revised 06/15/15, revealed care plan interventions should be initiated after each fall to attempt to prevent falls from occurring.</p> <p>1. Record review revealed the facility admitted</p>	F 280	<p>(Continued from Page 2)</p> <ol style="list-style-type: none"> The Director of Nursing changed Resident #10 to assist of 1 with grooming, toileting, ambulation, and transfers on 08/07/2015. The Director of Nursing updated the care plan on 07/30/2015 for hip and elbow protectors on resident #9 as a late entry for 07/14/2015. RN #2 in-serviced by Assistant Director of Nursing on 07/30/2015 regarding documentation of falls, completion of post fall investigation & determining root cause factor of fall, and care plan interventions. The Director of Nursing checked all residents that have fallen to ensure that all falls have been investigated to determine root cause of fall and appropriate care plan interventions are in place for those residents. Staff Development Nurse will in-service the Licensed Nursing Staff on fall prevention & documentation, investigation and determining root cause, and care plan interventions by 09/10/2015. The Director &/or Asst. Director of Nursing will review all falls, as they occur, for monitoring of documentation, determination of root cause, and accuracy of interventions that have been put into place. A fall report, including root cause and interventions put into place, will be completed by the Director &/or Asst. Director of Nursing, and given to the Administrator on a weekly basis for a period of twelve (12) months. The Administrator will report the weekly findings to the Quality Assurance Meeting on a monthly basis for a period of twelve (12) months. The Director of Nursing will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. <p>(Continued on Page 4)</p>	

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F 280	<p>Continued From page 3</p> <p>Resident #10 on 11/05/14 with diagnoses which included Dementia with Behavioral Disturbances, Alcohol Induced Amnestic Disorder, Wernicke's Korsakoff Syndrome and a History of a Cerebral Vascular Accident. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 05/31/15, revealed the facility assessed Resident #10's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of twelve (12), indicating the resident was interviewable. Further review revealed the resident required supervision and set-up assistance with transferring and ambulating the hallway and in room and utilized a cane for ambulation.</p> <p>Review of the Falls Care Plan, dated 05/18/15, revealed the resident was at risk for falls due to a history of falls, weakness and periods of confusion. Interventions were for the Falling Star Program; monitor for activity tolerance and encourage rest periods; to have the resident to wear shoes and non-skid socks with all transfers; monitor for the causative factor for the falls; and, to encourage the resident to call for assistance prior to ambulation or transfers.</p> <p>Review of the Falls Event Reports for Resident #10, dated 03/25/15, 04/03/15, 04/03/15, 05/05/15, 05/17/15, 06/02/15, 06/28/15 and twice on 07/01/15 and interview with the DON on 07/30/15 at 4:38 PM, revealed the resident experienced nine (9) falls due to the resident's failure to request assistance with transfers and ambulation, with only one (1) injury and this was an abrasion to the top of the head on 05/17/15. However, the unassisted transfers were not identified as the causative factor of the falls and an intervention for a bed alarm did not occur until</p>	F 280	<p>(Continued from Page 3)</p> <p>11. Quality Assurance Committee members are as follows: Dr. Amelia Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherri Likens, LPN, HR/SD</p>	09/13/2015
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F 280	<p>Continued From page 4 after the ninth fall. In addition, further review of the 05/18/15 Fall Care Plan revealed the bed alarm was not added to the care plan interventions, as of 07/30/15.</p> <p>Observation of Resident #10, on 07/28/15 at 3:18 PM, revealed the resident was resting quietly supine in bed with no bed alarm to bed but the resident's wheelchair had a chair alarm attached.</p> <p>Interview with the DON, on 07/30/15 at 4:38 PM, revealed the interventions implemented to prevent further falls for Resident #10 were for educating the resident on the use of the call light and did not change after the first two (2) falls. She stated on the third fall, Occupational Therapy screened yet had no new recommendations and on the fourth fall, the staff were encouraged to ensure the resident's personal items were in reach and to prompt the resident to request help. She said the fifth and sixth fall were due to the resident's footwear after getting up unassisted and on the seventh fall, the resident was placed on the Falling Star Program, which interview with the DON revealed this to mean the staff need to be monitoring the resident closer. She stated on the eighth fall, the resident rolled out of bed, due to being hungry and the staff were to offer snacks. After the ninth fall, a bed alarm was placed. The DON stated the interventions of reminding the resident to call for assistance with ambulation were not effective for this resident and did not address the root cause of the falls or prevent further falls.</p> <p>2. Record review revealed the facility admitted Resident #9 on 08/18/14 with diagnoses which included Dementia, Hereditary and Idiopathic Peripheral Neuropathy, Vitamin B-12 Deficiency</p>	F 280			

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F 280	Continued From page 5 Anemia, Paralysis Agitans, and Depressive Disorder. Review of Resident #9's Fall Care Plan, dated 05/26/15, revealed the resident has tendency to lay self in floor with interventions to monitor and track falls as they occur for causative factor, assist of one (1) as needed for transfers and ambulation, and to conduct safety checks every fifteen (15) minutes to address wants/needs. Review of an Unwitnessed Incident Description, dated 07/10/15, revealed Resident #9 was found in floor with resident assessed with no injury and relocated to bed; however, further review of the care plans revealed there was no Post Fall Care Plan completed for Resident #9 for the 07/10/15 fall and no intervention to address the root cause of this fall per facility policy. Interview with Registered Nurse (RN) #2, on 07/30/15 at 3:50 PM, revealed she did not do a Post Fall Care Plan for the 07/10/15 unwitnessed fall. She stated staff assisted the resident up and relocated him/her to the bed. She said she should have developed an intervention to address the cause of the fall. Interview with the Assistant Director of Nursing (ADON), on 07/30/15 at 4:20 PM revealed there was no information for the fall for Resident #9 on 07/10/15.	F 280			
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.	F 281	483.20(k)(3)(i) 1. Staff Development Nurse in-serviced CNA #6 and LPN #6 on proper use of gait belt on 07/30/2015. (Continued on Page 7)		

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F 281	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to provide services by qualified persons for one (1) of fifteen (15) sampled residents. Certified Nurse Aide (CNA) #6 and Licensed Practical Nurse (LPN) #6 transferred Resident #6, a quadriplegic, from a broda chair to bed without the use of a gait belt per facility policy.</p> <p>The findings include:</p> <p>Review of the facility policy titled , Transfer Resident/Ambulate/Mechanical Lifts/Gait Belts (Transfer Helpless Resident from Bed to Chair), not dated, revealed for staff to assist resident to a sitting position, apply transfer belt, position chair to resident's strong side parallel to or at a 45 degree angle to bed (when moving from bed to chair), lock wheels of chair, stand directly in front of the resident, grasp back of the belt, support resident knees and feet with your knees and feet, have resident lean forward and instruct resident to push up as much as possible while you assist him/her up by straightening your legs and hips and holding onto the belt. Pivot body as well as residents' body, assist the resident to the chair, if applicable.</p> <p>Record review revealed the facility admitted Resident #6 on 05/23/14 with diagnoses which included Quadriplegia and Quadriparesis C1-C4 Complete, Anxiety State, Depressive Disorder, Chronic Pain, and Urinary tract Infection. Review of the Annual Minimum Data Set (MDS) Assessment, dated 05/10/15, revealed the facility</p>	F 281	<p>(Continued from Page 6)</p> <ol style="list-style-type: none"> On 07/30/2015 the Director of Nursing monitored gait belt usage on resident #6 to ensure that gait belts were being used according to policy & procedure. The Director of Nursing monitored all residents to ensure gait belts were being used on 07/30/2015. The Staff Development Nurse will in-service all of the nursing on the Transfer Policy and Procedure to ensure proper use of gait belts by 09/08/2015. The Director &/or Asst. Director of Nursing will complete weekly audits for a period of twelve (12) months of the nursing staff to ensure proper use of gait belts. The Director of Nursing will forward the audit report to the Administrator on a weekly basis. The Administrator will report the finding of the audit report to the Quality Assurance Committee monthly for a period of twelve (12) months. The Director of Nursing will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. Quality Assurance Committee members are as follows: Dr. Amelia Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherri Likens, LPN, HR/SD 	09/13/2015
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F 281	Continued From page 7 assessed Resident #6's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) indicating the resident was interviewable. In addition, the resident was assessed to require total assistance with activities of daily living (ADLs). Observation on 07/28/15 at 2:45 PM revealed Resident #6 was assisted by two (2) staff (LPN #6 and CNA #6) from a Broda chair to the bed without the use of a gait belt. Interview with LPN #6, on 07/28/15 at 3:50 PM, revealed she did not use a gait belt when transferring Resident #6 from Broda chair to the bed. LPN #6 stated the gait belt should have been used for the transfer and the resident's shoulder could have been hurt or the resident could have been dropped. LPN #6 said a gait belt was a part of the uniform and should be with staff at all times. Interview with LPN #7, on 07/30/15 at 3:03 PM, revealed the staff should use a gait belt with all transfers. Interview with the Director of Nursing (DON), on 07/30/15 at 10:43 AM, revealed any transfer was a gait belt transfer, and the gait belt was supposed to be with staff at all times. The DON stated the gait belt should be used for a quadriplegic because it would not put pressure under the arms and if pressure was applied under the arms it "could take the shoulders out, they are dead weight".	F 281			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	483.20(k)(3)(ii) (Continued on Page 9)		

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F 282	<p>Continued From page 8</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to follow the interventions of the care plan for three (3) of fifteen (15) sampled resident (Resident #3, Resident #7 and Resident #10). The staff failed to implement the care plan for Resident #3's related to placing the resident's hands on top of pillows and blankets when in bed, Resident #7 related to the assist of one (1) staff for ambulation and Resident #10 related to a bed alarm.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Planning", last revised 03/04/11, revealed the Resident Assessment Instrument (RAI) process shall be adhered to by the interdisciplinary team to develop an accurate and individualized plan of care reflective of resident needs to ensure quality of care. The policy did not address implementation of the care plan.</p> <p>1. Record review revealed the facility admitted Resident #3 on 05/22/15 with diagnoses which included Left Traumatic Subarachnoid Hemorrhage, Left Subdural Hematoma, and Brain Compression. Review of Admission Minimum Data Set (MDS) Assessment, dated 06/01/15, revealed the facility assessed Resident #3's cognition as severely impaired which</p>	F 282	<p>(Continued from Page 8)</p> <ol style="list-style-type: none"> The Director of Nursing updated the care plan for resident #3 on 07/29/2015 to add skin sleeves to BUE on at all times except during hygiene & skin care. The Director of Nursing updated the Post Fall care plan intervention on resident #7 from assist of 1 to assist of 1 as needed with transfers and ambulation to reflect current status on 08/07/2015. The Director of Nursing updated resident #10's care plan to include the bed alarm and chair alarm on 07/30/2015. On 07/30/2015 the Director of Nursing reviewed all residents with alarms & special equipment to ensure proper placement of such devices. All nursing staff will be in-serviced on proper placement and observation of all alarms on 09/08/2015 by Staff Development Nurse. The Director of Nursing will ensure alarm placement is placed on Treatment record and licensed nursing staff will sign off each shift that alarm is in place and functioning properly. The Director &/or Asst. Director of Nursing will audit alarms weekly to ensure adequate placement of such devices for a period of twelve (12) months. The weekly Alarm Audit Report will be forwarded to the Administrator by the Director of Nursing on a weekly basis. The Administrator will report finding of the Weekly Alarm Audit Report to the Quality Assurance Committee monthly for a period of twelve (12) months. The Director of Nursing will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. (Continued on Page 10) 	

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F 282	<p>Continued From page 9</p> <p>Indicated the resident was not interviewable. The resident was unable to complete a Brief Interview for Mental Status (BIMS).</p> <p>Review of Resident #3's Wound Care Plan, dated 07/24/15, revealed an intervention to ensure both resident's hands were placed on top of a pillow and on top of blankets while in bed.</p> <p>Observation of Resident #3 on 07/29/15 at 8:40 AM and 10:10 AM, revealed both of Resident #3's hands and arms were under his/her blankets.</p> <p>2. Record review revealed the facility admitted Resident #7 on 10/28/13 with diagnoses which included Alzheimer's, Anxiety, Depressive Disorder, Anemia, Hypertension, Dementia with Psychosis, and Osteoporosis.</p> <p>Review of Quarterly MDS Assessment, dated 06/14/15, revealed the facility assessed Resident #7's cognition as severely impaired with a BIMS score of three (3), which indicated the resident was not interviewable. In addition, Resident #7 required one (1) staff physical assist for walking in the room and in the corridor.</p> <p>Review of Resident #7's At Risk for Falls Care Plan, dated 06/26/15, revealed an intervention for assist of one (1) as needed (PRN) for ambulation. However, review of Resident #7's Post Fall Care Plan, dated 07/22/15, revealed he/she had a fall on 07/22/15 with an intervention of assist of one staff for ambulation added as an immediate intervention post fall. In addition, review of Resident #7's Post Fall Care Plan, dated 07/25/15, revealed he/she had a fall on 07/25/15 with an intervention of staff were educated that the resident was to be a one (1) assist anytime</p>	F 282	<p>(Continued from Page 9)</p> <p>11. Quality Assurance Committee members are as follows: Dr. Amelia Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherri Likens, LPN, HR/SD</p>	09/13/2015	

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F 282	<p>Continued From page 10</p> <p>he/she is ambulating added as an immediate intervention post fall.</p> <p>Observation of Resident #7, on 07/29/15 at 01:30 PM and on 07/30/15 at 10:30 AM, revealed he/she was ambulating with the use of a standard walker in the front lobby area with no staff assisting or monitoring the resident.</p> <p>3. Record review revealed the facility admitted Resident #10 on 11/05/14 with diagnoses which included Dementia with Behavioral Disturbances, Alcohol Induced Amnestic Disorder, Wernicke's Korsakoff Syndrome and a History of a Cerebral Vascular Accident.</p> <p>Review of the quarterly MDS assessment, dated 05/31/15, revealed the facility assessed Resident #10's cognition as moderately impaired with a BIMS score of twelve (12), indicating the resident was interviewable. Further review revealed the resident required supervision and set-up assistance with transferring and ambulating the hallway and room and utilized a cane for ambulation.</p> <p>Review of the Falls Event Report, dated 07/01/15, revealed Resident #10 had a fall and an intervention was added to have a bed alarm. However, review of the 05/18/15 Fall Care Plan revealed this was not added to the care plan interventions, as of 07/30/15.</p> <p>Observation of the resident on 07/28/15 at 3:18 PM, revealed the resident resting quietly supine in bed, with a nearby walker and wheel chair, with a chair alarm attached and no bed alarm in use.</p> <p>Interview with Assistant Director of Nursing</p>	F 282		

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F 282	Continued From page 11 (ADON), on 07/30/15 at 2:30 PM, revealed she expected staff to follow the resident care plans as the care plans are a guide to taking care of the residents. She further stated the administrative nurses are to review the falls information and determine if post fall immediate interventions that were put into place immediately following a fall are appropriate and if assessed to be a appropriate the intervention will continue to be used and if it was assessed that a different intervention was needed then a new intervention as assessed to be appropriate will be implemented and added. She stated she expected staff to follow the resident care plans as the care plans are a guide to taking care of the residents.	F 282			
F 315 SS=D	Interview with Director of Nursing (DON), on 07/30/15 at 02:35 PM, revealed she expected staff to follow the care plan interventions for all residents. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	483.25(d) 1. CNA #1 and RN #1 were instructed on proper catheter care for Resident #3 by Asst. Director of Nursing on 07/29/2015. 2. The Director of Nursing checked all residents with catheters to ensure that proper catheter care is conducted on 07/29/2015. 3. CNA #1 and RN#1 will complete a Catheter Care Procedure in-service and return demonstration with proper technique to the Staff Development nurse on 09/04/2015. 4. All nursing staff will complete a Catheter Care Procedure in-service and return demonstration with proper technique, and training on proper bag and tubing placement by 09/11/2015 by Staff Development Nurse. (Continued on Page 13)		

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F 315	<p>Continued From page 12</p> <p>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure appropriate treatment and services were provided to prevent an infection of the urinary tract for one (1) of fifteen (15) sampled residents (Resident #3). Certified Nurse Aide (CNA) #1 failed to properly clean and rinse the resident's perineal area and indwelling urinary catheter while providing catheter care.</p> <p>The findings include:</p> <p>Review of the facility policy for Urinary Catheter Care, not dated, revealed facility staff should gently wash around the opening of the urethra with soap and water, then holding the catheter near the meatus, clean the catheter from the meatus down the catheter about four (4) inches, using soap, water, and a clean wash cloth. Clean downward away from the meatus with one stroke. Repeat as needed with a clean area on the wash cloth each time. Rinse and pat dry.</p> <p>Record review revealed the facility admitted Resident #3 on 05/22/15 with diagnoses which included Left Traumatic Subarachnoid Hemorrhage, Left Subdural Hematoma, and Brain Compression. Review of the Admission Minimum Data Set (MDS) Assessment, dated 06/01/15, revealed he/she could not be assessed for a Brief Interview for Mental Status (BIMS) score due to severely impaired cognition which indicated he/she was not interviewable.</p> <p>Observation of Resident #3 receiving indwelling urinary catheter care, on 07/29/15 at 2:07 PM by Certified Nurse Aide (CNA) #1, revealed the CNA placed equipment on the bedside table to provide catheter care to include a basin with clean warm</p>	F 315	<p>(Continued from Page 12)</p> <ol style="list-style-type: none"> All non-licensed staff will be in-serviced on proper notification to nursing staff when a resident needs to be relocated or belongings need to be moved by the Staff Development Nurse on 09/08/2015 The Staff Development Nurse or the Director of Nursing will randomly audit two (2) CNA's and one (1) licensed nurse each month for catheter care procedure for a period of twelve (12) months. The Staff Development Nurse will report the Catheter Care Procedure audit results to the Administrator monthly. The Administrator will report the Catheter Care Procedure Audit results to the Quality Assurance Committee monthly for a period of twelve (12) months. The Director of Nursing will monitor & be responsible for follow-up and recommendations from the Quality Assurance Committee. Quality Assurance Committee members are as follows: Dr. Amelia Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherri Likens, LPN, HR/SD 	09/13/2015	

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F 315	Continued From page 13 water with one (1) washcloth placed in water; a second basin with warm soapy water with one (1) washcloth in that basin; and, a clean clean dry towel on bedside table. CNA #1 donned gloves, and removed the resident's covers and repositioned the resident's gown. CNA #1 was observed taking a clean washcloth out of the soapy water basin and cleansed Resident #3's perineal/urethral area. CNA #1 then proceeded to cleanse the indwelling urinary catheter from the meatus down the catheter with the same washcloth. CNA #1 initially secured the urinary catheter approximately four (4) inches down the catheter and proceeded to cleanse the catheter away from the meatus toward where she had secured the catheter with her left hand, she then repositioned her left hand to secure the catheter directly above the meatus approximately one (1) inch above the meatus and clean down the catheter again away from the meatus. CNA #1 then placed the contaminated soapy washcloth into the rinse water basin with the clean rinse washcloth. CNA #1 then went to reach for the clean washcloth in the rinse basin to remove a washcloth from the basin, but Registered Nurse (RN) #1 verbally informed CNA #1 to stop due to she contaminated that basin by placing the dirty washcloth in the rinse basin. CNA #1 then proceeded to pick up a pack of disposable sanitary wash clothes to use one to rinse Resident #3; however, RN #1 again verbally informed CNA #1 that was not appropriate to use the disposable sanitary washcloths for rinsing. CNA #1 proceeded to leave the resident's room to go obtain a clean washcloth for rinsing. CNA #1 returned to Resident #3 room after several minutes with gloves on and with a wet washcloth in her hand and proceeded to rinse Resident #3's penis and catheter. CNA #1 was verbally	F 315			

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F 315	<p>Continued From page 14</p> <p>informed by RN #1 that she was supposed to pat dry the perineal area and catheter area after the areas were rinsed. After being instructed to do such, CNA #1 grabbed a clean towel and patted the areas dry.</p> <p>Interview with CNA #1, on 07/29/15 at 2:25 PM, revealed the CNA had been trained to provide urinary catheter care every shift and on an "as needed" basis. CNA #1 stated she had been trained to use warm water, soap, and washcloths to clean the resident's perineal/urethral area, discard the soiled washcloth, rinse the area with a clean washcloth, discard the soiled washcloth used for rinsing, and use two (2) additional clean washcloths to clean and rinse the catheter. CNA #1 stated she should have had more washcloths for cleaning and rinsing the perineal/urethral area and catheter on hand and available.</p> <p>Interview with RN #1, on 07/29/15 at 02:30 PM, revealed she expected staff to have available supplies on hand prior to the start of catheter/peri-care. She stated she expected staff to have changed gloves prior to restarting catheter care after leaving the room for supplies and returning to the resident's room with the same gloves on.</p> <p>Interview with Director of Nursing (DON), on 07/30/15 at 02:05 PM, revealed she expected staff to be prepared prior to starting catheter cares by having the supplies on hand at bedside. She further stated she expected staff to follow catheter care as per policy.</p> <p>Further observation of Resident #3, on 07/30/15 at 10:30 AM, revealed he/she was sitting up in a geri-chair in room with his/her urinary catheter</p>	F 315		

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F 315	Continued From page 15 drainage bag resting on top of his/her abdomen. Interview with Licensed Practical Nurse (LPN) #2, on 07/30/15 at 10:40 AM, revealed she expected staff to position the urinary catheter bag below the resident's bladder and it was not appropriate to rest a urinary drainage bag on top of a resident due to this was an infection control issue and also this would prevent the proper drainage of urine into the drainage bag which could cause a resident to develop an infection. Interview with Assistant Director of Nursing (ADON) on 07/30/15 at 10:35 AM, revealed she expected staff to anchor the urinary catheter drainage bag to the geri-chair and it was unacceptable for a urinary drainage bag to be placed on top of a resident as this was an infection control issue. She further stated the drainage bags are to be anchored below the resident's bladder to promote proper urinary drainage. Further interview with DON, on 07/30/15 at 2:35 PM, revealed she expected staff to anchor a indwelling urinary catheter bag below a resident's bladder to maintain proper urinary flow into the drainage bag and that staff were never to lay a urinary drainage bag on top of a resident as this was an infection control concern.	F 315			
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.	F 323	483.25(h) 1. The Director of Nursing updated the Post Fall care plan intervention for assist of 1 to assist of 1 as needed with transfers and ambulation on resident #7 to reflect current status on 08/07/2015. (Continued on Page 17)		

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F 323	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for three (3) of fifteen (15) sampled residents (Resident's #8, #7, and #10). Staff failed to ensure Resident #7 and Resident #10 had adequate supervision for ambulation and failed to ensure a gait belt was used for Resident #6 with transfers to prevent accidents.</p> <p>The findings include:</p> <p>Review of facility policy titled "Resident Incident/Accident Policy", last updated 06/15/15, revealed it was the policy of the facility to attempt to provide a safe environment free from accidents with proactive, preventative care interventions.</p> <p>1. Record review revealed the facility admitted Resident #7 on 10/28/13 with diagnoses which included Alzheimer's, Anxiety, Depressive Disorder, Anemia, Hypertension, Dementia with Psychosis, and Osteoporosis. Review of Quarterly Minimum Data Set (MDS) Assessment, dated 06/14/15, revealed he/she had a BIMS Score of three (3), which indicated the resident was not interviewable. Further Review of Quarterly MDS dated 06/14/15, revealed Resident #7 was coded as needing limited assistance of one (1) staff physical assist for walking in the room and in the corridor.</p>	F 323	<p>(Continued from Page 16)</p> <ol style="list-style-type: none"> 2. Resident #10 only had 1 fall on 04/03/2015. 3. The Director of Nursing updated the care plan of resident #10 adding the bed alarm & chair alarm on 07/30/2015. 4. Resident #10 was changed to assist of 1 with grooming, toileting, ambulation, and transfers by the Director of Nursing on 08/07/2015. 5. Staff Development Nurse in-serviced CNA #6 and LPN #6 on proper use of gait belts on 07/30/2015. 6. The Director of Nursing reviewed all residents plan of care to ensure that transfers are being performed per individual plan of care on 07/31/2015 7. The Staff Development nurse will in-service all nursing staff on the Transfer Policy & Procedure to ensure proper use of gait belts by 09/08/2015 8. The Director of Nursing changed the recording of the alarm placement to place on Treatment record and licensed nursing staff will sign off each shift that alarm is in place and functioning appropriately on 09/13/2015. 9. All nursing staff will be in-serviced on proper placement and observation of all alarms on 09/08/2015 by Staff Development Nurse 10. The Director &/or Asst. Director of Nursing will complete weekly audits of the nursing staff to ensure proper use of gait belts for a period of twelve (12) months. 11. The Director &/or Asst. Director of Nursing will audit alarms weekly to ensure appropriate placement of such devices for a period of twelve (12) months. 12. The Weekly Alarm Audit Report and Gait Belt Audit Report will be forwarded to the Administrator by the Director of Nursing on a weekly basis.. <p>(Continued on Page 18)</p>		

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F 323	<p>Continued From page 17</p> <p>Review of Resident #7's Comprehensive Care Plan "At risk for falls" dated 06/26/15, revealed this resident was at risk for falls and/or injury related to having unsteady gait, history of falls, knee pain, combative behaviors, wandering, and increased confusion. Further review of this care plan, revealed an intervention in place for assist of one (1) as needed (PRN) for ambulation.</p> <p>Review of Resident #7's Post Fall Care Plan, dated 07/22/15, revealed he/she had a fall on 07/22/15 with an intervention of assist of one (1) staff for ambulation added as an immediate intervention post fall. Review of Resident #7's Post Fall Care Plan, dated 07/25/15, revealed he/she had a fall on 07/25/15 with an intervention that staff were educated that the resident was to be a one (1) assist anytime he/she is ambulating added as an immediate intervention post fall.</p> <p>Observation of Resident #7, on 07/29/15 at 1:30 PM, revealed he/she was ambulating with the use of a standard walker in the front lobby area with no staff assisting or monitoring the resident.</p> <p>Interview with Assistant Director of Nursing (ADON), on 07/30/15 at 2:30 PM, revealed she expected staff to follow the resident care plans as the care plans are a guide to taking care of the residents. She further stated the administrative nurses are to review the falls information and determine if post fall immediate interventions that were put into place immediately following a fall are appropriate and if assessed to be a appropriate the intervention will continue to be used and if it was assessed that a different intervention was needed then a new intervention as assessed to be appropriate will be implemented and added.</p>	F 323	<p>(Continued from Page 17)</p> <p>13. The Administrator will report findings of the Weekly Alarm Audit Report to the Quality Assurance Committee monthly for a period of twelve (12) months.</p> <p>14. The Director of Nursing will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee.</p> <p>15. Quality Assurance Committee members are as follows: Dr. Amella Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherri Likens, LPN, HRVSD</p>	09/13/2015	

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NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. 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 323	<p>Continued From page 18</p> <p>Interview with Director of Nursing (DON), on 07/30/15 at 02:35 PM, revealed she expected staff to review the care plans and follow the care plan interventions for all residents. This interview further revealed there was not system in place to monitor and make sure Resident #7 was provided staff assistance of one (1) while up ambulating throughout the facility.</p> <p>2. Record review revealed the facility admitted Resident #10 on 11/05/14 with diagnoses which included Alcohol Induced Persisting Amnestic Disorder, Wernicke's Korsakoff Syndrome and a History of a Cerebral Vascular Accident. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/31/15, revealed the facility assessed Resident #10's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was interviewable. Further review revealed the resident required supervision and a one person assist with bed mobility, supervision and set-up assistance with transferring and ambulating the hallway and room, and utilized a cane for ambulation.</p> <p>Review of the falls care plan, dated 05/18/15, revealed the resident was at risk for falls due to a history of falls, weakness and periods of confusion. Interventions included non-skid socks and the Falling Star Program.</p> <p>Review of the Falls investigations, Falls Event Reports and Post Fall Care Plans for Resident #10, dated 03/25/15, 04/03/15, 04/03/15, 05/05/15, 05/17/15, 06/02/15, 06/28/15 and twice on 07/01/15 and interviews with the DON, on 07/30/15 at 4:38 PM, revealed the resident</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>experienced nine falls due to the failure to request assistance with transfers and ambulation with only one (1) minor injury of an an abrasion to the top of the head; however, an intervention for a bed alarm was not implemented until 07/01/15.</p> <p>Observation of Resident #10, on 07/28/15 at 3:18 PM, revealed the resident was resting quietly supine in bed with no bed alarm in use. A wheelchair were nearby with a chair alarm attached.</p> <p>Interview with the DON, on 07/30/15 at 4:38 PM, revealed for all nine incidents, the resident was found in the floor after rolling out of bed, or transferring him/herself out of the bed or chair, without requesting assistance and was found sitting in the floor. Interventions, to prevent further falls for Resident #1, were for educating the resident on the use of the call light and did not change after the first two falls. On the third fall, Occupational Therapy screened yet had no new recommendations. On the fourth fall, the staff were encouraged to ensure the resident's personal items were in reach and to prompt the resident to request help. The fifth and sixth fall were due to footwear after getting up unassisted and on the seventh fall, the resident was placed on the Falling Star Program, which interview with the DON revealed this to mean the staff need to be monitoring the resident closer. On the eighth fall, the resident rolled out of bed, due to being hungry and the staff were to offer snacks. After the ninth fall, a bed alarm was placed. The DON stated the interventions of reminding the resident to call for assistance with ambulation were not effective, for this resident and did not address the root cause of the falls or prevent further falls. The DON was unaware the resident was in bed,</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>without the use of a bed alarm. There was no system in place to monitor the alarm use for this resident.</p> <p>3. Review of the facility policy titled , Transfer Resident/Ambulate/Mechanical Lifts/Gait Belts (Transfer Helpless Resident from Bed to Chair), not dated, revealed for staff to assist resident to a sitting position, apply transfer belt, position chair to resident's strong side parallel to or at a 45 degree angle to bed (when moving from bed to chair), lock wheels of chair, stand directly in front of the resident, grasp back of the belt, support resident knees and feet with your knees and feet, have resident lean forward and instruct resident to push up as much as possible while you assist him/her up by straightening your legs and hips and holding onto the belt. Pivot body as well as residents' body, assist the resident to the chair, if applicable.</p> <p>Record review revealed the facility admitted Resident #6 on 05/23/14 with diagnoses which included Quadriplegia and Quadriparesis C1-C4 Complete, Anxiety State, Depressive Disorder, Chronic Pain, and Urinary tract Infection. Review of the Annual Minimum Data Set (MDS) Assessment, dated 05/10/15 revealed the facility assessed Resident #6's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) indicating the resident was interviewable. In addition, the resident was assessed to require total assistance with activities of daily living (ADLs).</p> <p>Observation on 07/28/15 at 2:45 PM revealed Resident #6 was assisted by two (2) staff (Licensed Practical Nurse (LPN) #6 and Certified Nursing Aide (CNA) #6) from a Broda chair to bed</p>	F 323			

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F 323	<p>Continued From page 21 without the use of gait belt.</p> <p>Interview with LPN #6, on 07/28/15 at 3:50 PM, revealed she did not use a gait belt when transferring Resident #6 from Broda chair to the bed. LPN #6 stated the gait belt should have been used for the transfer and the resident's shoulder could be hurt or the resident could be dropped. LPN #6 further revealed a gait belt was a part of the uniform and should be with staff at all times.</p> <p>Interview with LPN #7, on 07/30/15 at 3:03 PM, revealed the staff should use a gait belt with all transfers.</p> <p>Interview with the Director of Nursing (DON), on 07/30/15 at 10:43 AM, revealed any transfer was a gait belt transfer, and the gait belt was supposed to be with staff at all times. The DON stated the gait belt should be used for a quadriplegic because it would not put pressure under the arms and if pressure was applied under the arms it "could take the shoulders out, they are dead weight".</p>	F 323		
F 369 SS=D	<p>483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS</p> <p>The facility must provide special eating equipment and utensils for residents who need them.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility did not implement assistive devices for</p>	F 369	<p>483.35(g)</p> <ol style="list-style-type: none"> 1. The Director of Nursing clarified the Physician's order on 07/30/2015 to ensure resident #8 has yogurt placed in bowl during meal. 2. The Dietary Manager provided a baby spoon for resident #15 on 07/29/2015. 3. The Dietary Manager in-serviced the dietary staff on 07/29/2015 regarding compliance with physician's orders concerning adaptive equipment. <p>(Continued on Page 23)</p>	

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F 369	<p>Continued From page 22</p> <p>meal consumption for two (2) of fifteen (15) sampled residents (Resident #8 and Resident #15). Resident #8 did not have yogurt in a bowl per meal card and Resident #15 did not have a baby spoon for his/her meal.</p> <p>The findings include:</p> <p>Review of Resident Rights with no date revealed residents have the right to receive services with reasonable accommodations to individual needs and preferences.</p> <p>Review of a facility policy with no date and no title, revealed to ensure the safety of residents related to diet changes and adaptive equipment Speech Therapy will determine the need for adaptive devices and will make a written request to nursing for an approval order to be obtained by the attending physician.</p> <p>1. Record review revealed the facility admitted Resident #8 on 10/24/13 with diagnoses which included Alzheimer's Disease, Anemia, Anxiety, Depressive Disorder, Paralysis Agitans, Macular Degeneration, Osteoporosis, Transient Cerebral Ischemia, and Lumbago. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/03/15, revealed the facility assessed Resident #8's cognition as severely impaired which indicated the resident was not interviewable. In addition, the resident required extensive assistance with activities of daily living.</p> <p>Review of Resident #8's Meal Card, not dated, revealed the resident's yogurt should be in a bowl.</p> <p>Observation on 07/29/15 at 1:00 PM revealed</p>	F 369	<p>(Continued from Page 22)</p> <ol style="list-style-type: none"> 4. The Director of Nursing audited all residents with special adaptive equipment on 07/29/2015. 5. Dietary Manager will complete a weekly audit of all assistive device orders to ensure devices are readily available for use for a period of twelve (12) months. 6. Dietary Manager will report audit findings to the Administrator weekly. 7. The Administrator will report Weekly Audit results to the Quality Assurance Committee monthly for a period of twelve (12) months. 8. The Director of Nursing will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. 9. Quality Assurance Committee members are as follows: Dr. Amella Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherril Likens, LPN, HR/SD 	09/13/2015
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F 369	<p>Continued From page 23</p> <p>Resident #8 did not have yogurt served in a bowl per meal card.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 07/29/15 at 1:35 PM, revealed Resident #8's meal card indicated to place yogurt in a bowl and she should have checked the meal card and it would be easier for the resident to eat the yogurt with it in a bowl.</p> <p>2. Record review revealed the facility admitted Resident #15 on 01/05/15 with diagnoses which included Alzheimer's Disease, Hypothyroidism, and Hypertension. Review of the Quarterly MDS Assessment, dated 07/05/15 revealed the facility assessed Resident #15's cognition as severely impaired with a BIMS score of three (3) which indicated the resident was not interviewable. In addition, the resident required extensive assistance with activities of daily living.</p> <p>Review of Resident #15's Meal Card, not dated, revealed Resident #15 required a baby spoon for eating.</p> <p>Observation on 07/29/15 at 1:00 PM revealed Resident #15 was not being fed with a baby spoon by CNA # 4 as stated on meal card.</p> <p>Interview with CNA #4, on 07/29/15 at 1:30 PM, revealed Resident #15 should be fed with a baby spoon and it was on the meal card for the resident to be fed with a baby spoon.</p> <p>Observation and interview on 07/29/15 at 1:32 PM revealed CNA # 5 telling dietary staff she needed a baby spoon for Resident #15.</p> <p>Interview with the Dietary Aide, on 07/29/15 at</p>	F 369		
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F 369	Continued From page 24 1:40 PM, revealed trays should be checked before going out of the kitchen to the residents. Interview with the Dietary Supervisor, on 07/29/15 at 2:05 PM, revealed assistive devices should come out when the tray is served to the resident, and if dietary does not catch the oversight the CNA should. Interview with the Director of Nursing (DON), on 07/30/15 at 3:05 PM, revealed if an assistive device is listed on the meal card, then the CNA should ensure the meal card is followed.	F 369		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	483.65 1. CNA #6 was in-serviced by Staff Development Nurse regarding proper infection control when handling contaminated equipment on 07/28/2015. 2. Resident #6's call bell was disinfected by housekeeping staff on 07/28/2015. 3. The Director of Nursing checked all resident equipment to ensure the equipment was properly cleaned & disinfected on 07/28/2015. 4. All staff will be in-serviced on appropriate infection control measures on 09/08/2015 by Staff Development Nurse. 5. The Staff Development Nurse or the Director of Nursing will perform weekly audits of resident care regarding infection control procedures. 6. The Staff Development Nurse will report audit results to the Administrator weekly. 7. The Administrator will report the audit findings to the Quality Assurance Committee for review monthly for a period of twelve (12) months. 8. The Director of Nursing will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. (Continued on Page 26)	

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F 441	<p>Continued From page 25</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of fifteen (15) sampled residents (Resident #6). Certified Nurse Aide (CNA) #6 placed Resident #6's catheter bag on the side of his/her bed, then placed the mouth call light close to the resident's mouth without changing gloves.</p> <p>The findings include: Review of facility's policy titles "Infection control / Standard Precautions", not dated, revealed Standard Precautions will be used in the care of all residents regardless of their diagnosis or presumed infection status. Under Handwashing it</p>	F 441	<p>(Continued from Page 25)</p> <p>9. Quality Assurance Committee members are as follows: Dr. Amella Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonla Bullock, RN, DON Tammy London, RN, ADON Vivian Kinstow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherri Likens, LPN, HR/SD</p>	09/13/2015

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F 441	<p>Continued From page 26</p> <p>states under number two (2): Wash hands or use waterless antiseptic agent immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments and to wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body sites. Under Gloves it states under number three (3): Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms.</p> <p>Record review revealed the facility admitted Resident #6 on 05/23/14 with diagnoses which included Quadriplegia and Quadriparesis C 1-C 4 Complete, Thrombocytopenia, Anxiety State, Depressive Disorder, Chronic Pain, and Urinary tract Infection.</p> <p>Observation on 07/28/15 at 2:45 PM revealed CNA #6 removed the catheter from the broda chair and attached it to side of the bed; then placed Resident #6's mouth call lights close to the resident's mouth without changing her gloves.</p> <p>Interview on 07/28/15 at 3:18 PM with CNA #6 revealed she did not change her gloves after she had touched Resident #6's catheter, pants, and brief and prior to placing Resident #6 mouth call light close to the resident's mouth. CNA #6 stated she should have changed her gloves before touching the mouth call light because of cross contamination.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 07/28/15 at 3:50 PM, revealed gloves should have been changed before touching the mouth</p>	F 441		

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F 441	Continued From page 27 call light because it could cause infection. Interview with the Assistant Director of Nursing (ADON) and Director of Nursing (DON), on 07/30/15 at 3:05 PM, revealed they expected staff to remove soiled gloves, wash/sanitize hands and don fresh gloves to prevent cross contamination and the risk of infection.	F 441		

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NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. 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 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, on 09/26/15, as alleged.	{K 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 GLENVIEW HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. 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: 1961.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (11).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1963, upgraded in 2003 with 4 smoke detectors and 2 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1961 and upgraded in 1986.</p> <p>GENERATOR: Type II generator installed in 2008. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was initiated on 07/29/15 and concluded on 07/30/14. The facility was found in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of fifty-three (53) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>The submission of this plan of correction does not constitute an admission of guilt by the facility of the cited deficiencies or any violation of a regulation or standard of care. Also, we reserve the right to take further action, including any and all legal means necessary, to resolve any dispute about the accuracy of this information.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Therome W. Cook</i>	TITLE NHA	(X6) DATE 09-24 2015
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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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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	
K 027 SS=1	FPA 101 LIFE SAFETY CODE STANDARD Floor openings in smoke barriers have at least a 20-minute fire protection rating or are at least 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, record review, and interview, the facility failed to provide hold open devices that automatically close smoke doors upon manual activation of the fire alarm system and upon activation of the local smoke detectors. The deficient practice had the potential to affect five (5) of five (5) smoke compartments, staff, and all residents. The facility has the capacity for sixty (60) beds with a census of fifty-three (53) the day of survey. The findings include: Record review on 07/29/15 at 9:40 AM, with the General Contractor revealed the facility had a	K 027	19.3.7.5 19.3.7.6 19.3.7.7 1. Smoke detectors ordered and scheduled to arrive on 09/22/2015. 2. Outside company contracted and scheduled to install smoke detectors on 09/25/2015. 3. Environmental services will test smoke detectors quarterly for a period of twelve (12) months to ensure proper functioning. 4. The quarterly test results will be forwarded to the Administrator. 5. The Administrator will forward the results to the Quality Assurance Committee quarterly for a period of twelve (12) months. 6. The Environmental Supervisor will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. 7. Quality Assurance Committee members are as follows: Dr. Amelia Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherri Likens, LPN, HR/SD
			09/28/2015

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K 027	<p>Continued From page 2</p> <p>total of four (4) smoke detectors installed and connected to the fire alarm; one (1) was installed on each side of the smoke doors by Room #24. One (1) smoke detector was installed in the Dining Room, and one (1) was installed outside the Laundry Room.</p> <p>Observation, on 07/30/15 at 11:50 AM, with the General Contractor revealed the hold open door devices installed to release the smoke doors by Room #37, the Therapy Room, and Room #4 did not have a smoke detector installed to release the doors upon the detection of smoke.</p> <p>Interview on 07/30/15 at 11:51 AM, with the General Contractor revealed the facility was unaware the hold open devices were to release upon activation of the smoke detectors.</p> <p>The census of fifty-three (53) was verified by the Administrator on 07/30/15. The findings were acknowledged by the Administrator and verified by the General Contractor at the exit interview on 07/30/15.</p> <p>Actual NFPA Standard: NFPA 101, 19.2.2.2.6. Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure (except boiler rooms, heater rooms, and mechanical equipment rooms) shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.</p> <p>Actual NFPA Standard: NFPA 101, 7.2.1.8.2. In</p>	K 027	

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(X4) ID PREFIX TAG K 027	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 027	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
	<p>Continued From page 3</p> <p>any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:</p> <ol style="list-style-type: none"> 1) Upon release of the hold-open mechanism, the door becomes self-closing. 2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. 3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. 4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. 5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair. <p>Actual NFPA Standard: NFPA 72, Section 2-10.6.5.2. If door release is intended to prevent smoke transmission from one space to another in one direction only, one detector located in the space to which smoke is to be confined shall be required, regardless of the depth of wall section above the door. Alternatively, a smoke detector conforming with 2-10.6.5.1.3 shall be permitted to be used.</p> <p>Actual NFPA Standard: NFPA 72, 2-10.6.5.1.3. If a detector is specifically listed for door frame mounting or if a listed combination or integral detector-door closer assembly is used, only one</p>		

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K 027	Continued From page 4 detector shall be required if installed in the manner recommended by the manufacturer. Actual NFPA Standard: NFPA 72, Section 3-9.8.3. All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.	K 027	
K 029 SS+D	NFPA 101 LIFE SAFETY CODE STANDARD 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 extinguishing system option 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 4 7/8 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) stroke compartments, residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-three (53).	K 029	19.3.2.1 1. Room #4 will not be used for storage effective 08/01/2015, therefore there is no need to install a door closure. 2. The Environmental Supervisor will audit all rooms in the facility to ensure that required door closures are utilized when necessary weekly for a period of twelve (12) months. 3. The audits will be given to the Administrator weekly. The Administrator will report the findings to the Quality Assurance Committee monthly for a period of twelve (12) months. 4. The Environmental Supervisor will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. 5. Quality Assurance Committee members are as follows: Dr. Amelia Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherri Likens, LPN, HR/SD
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K 029	<p>Continued From page 5</p> <p>The findings include:</p> <p>Observation, on 07/30/15 at 10:32 AM, with the General Contractor revealed Room #4 was being used to store linen carts and the door was not equipped with a self-closing device.</p> <p>Interview, on 07/30/15 at 10:33 AM, with the General Contractor revealed he was not aware of the requirements for protection from hazards.</p> <p>The census of fifty-three (53) was verified by the Administrator on 07/30/15. The findings were acknowledged by the Administrator and verified by the General Contractor at the exit interview on 07/30/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1 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:</p> <ol style="list-style-type: none"> 1) Boiler and fuel-fired heater rooms 2) Central/bulk laundries larger than 100 ft² (9.3 m²) 	K 029	

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K 029	<p>Continued From page 6</p> <ul style="list-style-type: none"> (1) Paint shops (1) Repair shops (1) Soiled linen rooms (1) Trash collection rooms (1) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (1) 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 field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:</p> <ul style="list-style-type: none"> (1) Upon release of the hold-open mechanism, the door becomes self-closing. 	K 029	

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K 029	<p>Continued From page 7</p> <p>(2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed.</p> <p>(3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®.</p> <p>(4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing.</p> <p>(5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.</p> <p>K 062 SSFF NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-three (53).</p> <p>The findings include:</p>	K 029	<p>19.7.6,4.6.12 NFPA 13, NFPA 25, 9.7.5</p> <ol style="list-style-type: none"> 1. The contracted sprinkler company performed an inspection and tested the sprinkler system on 06/09/2015. 2. The Environmental Supervisor will audit quarterly sprinkler inspections to ensure compliance for a period of twelve (12) months. 3. The audit report will be sent to the Administrator, who will report the findings to the monthly Quality Assurance Committee for a period of twelve (12) months. 4. The Environmental Supervisor will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. 5. Quality Assurance Committee members are as follows: Dr. Amella Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonla Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM (Continued on Page 9)

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K 062	<p>Continued From page 8</p> <p>sprinkler testing record review, on 07/29/15 at 9:37 AM, with the General Contractor revealed the facility failed to conduct the quarterly sprinkler inspection in the first (1st) quarter of 2015.</p> <p>interview, on 07/29/15 at 9:38 AM, with the General Contractor revealed the inspection for the first (1st) quarter was cancelled due to bad weather; however, it was not rescheduled.</p> <p>The census of fifty-three (53) was verified by the Administrator on 07/30/15. The findings were acknowledged by the Administrator and verified by the General Contractor at the exit interview on 07/30/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table</p>	K 062	<p>(Continued from Page 8)</p> <p>Shirley James, Environmental Supervisor Sherri Likens, LPN, HR/SD</p> <p>09/13/2015</p>

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K 062	Continued From page 9 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No.	K 062	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2015
NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. 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 062	Continued From page 10 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Gas relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1	K 062	

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K 062	Continued From page 11 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Reaction/Deluge Valves Friming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Friming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Reaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062	
K 075 SS=D	IFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space	K 075	19.7.5.5 1. The housekeeping supervisor removed the oversize container on 08/01/2015. 2. The housekeeping supervisor replaced the oversized container with a receptacle less than thirty-two (32) gallons on 08/01/2015. (Continued on Page 13)

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K 075

Continued From page 12
 does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5

This STANDARD is not met as evidenced by:
 Based on observation and interview, it was determined the facility failed to ensure linen or trash collection receptacles with capacities greater than thirty-two (32) gallon were stored in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-three (53).

The findings include:

Observation, on 07/30/15 at 12:49 PM, with the General Contractor revealed a trash container with a capacity of forty-five (45) gallons was being stored in the egress path located in the Front Hall by the Dining Room.

Interview, on 07/30/15 at 12:50 PM, with the General Contractor revealed he was not aware of the requirement for trash receptacles with capacities greater than thirty two (32) gallons.

K 075

(Continued from Page 12)
 3. The Environmental Supervisor will inspect the dining procedure weekly for a period of twelve (12) months to ensure compliance with containers.
 4. A weekly audit report will be given to the Administrator, who will then report the findings to the Quality Assurance Committee monthly for a period of twelve (12) months.
 5. The Environmental Supervisor will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee.
 6. Quality Assurance Committee members are as follows:
 Dr. Amella Kiser, Medical Director
 Lisa Wright, LPN, Pharmacy Consultant
 Yvonne W. Cook, Administrator
 Tonia Bullock, RN, DON
 Tammy London, RN, ADON
 Vivian Kinslow, RSC
 Sharon Bragg, CDM
 Shirley James, Environmental Supervisor
 Sherri Likens, LPN, HR/SD

09/13/2015

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(X4) ID PREFIX TAG K 075	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 075	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 144 SS=F	<p>Continued From page 13</p> <p>The census of fifty-three (53) was verified by the Administrator on 07/30/15. The findings were acknowledged by the Administrator and verified by the General Contractor at the exit interview on 07/30/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft² (20.4 L/m²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by:</p>	<p>K 144</p> <p>3.4.4.1</p> <ol style="list-style-type: none"> 1. By 09/13/2015 the Environmental Supervisor will purchase the supplies needed to test the electrolyte level of the generator batteries weekly for as long as this type of battery is in use as part of routine testing procedures. 2. The weekly test report will be given to the Administrator, who will then report the findings to the Quality Assurance Committee monthly for a period of twelve (12) months. 3. The Environmental Supervisor will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. <p>(Continued on Page 15)</p>	(X5) COMPLETION DATE

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K 144	<p>Continued From page 14</p> <p>Based on an interview and record review, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty (60) beds with a census of fifty-three (53) on the day of the survey.</p> <p>The findings include:</p> <p>Generator documentation review, on 07/30/15 at 11:13 AM, with the General Contractor revealed the facility did not have documentation that the battery electrolyte levels were checked weekly.</p> <p>Interview, on 07/30/15 at 11:14 AM, with the General Contractor revealed he was not aware of the requirement.</p> <p>The census of fifty-three (53) was verified by the Administrator on 07/30/15. The findings were acknowledged by the Administrator and verified by the General Contractor at the exit interview on 07/30/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>1.1.1*</p> <p>The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p>	K 144	<p>(Continued from Page 14)</p> <p>4. Quality Assurance Committee members are as follows: Dr. Amelia Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sherril Likens, LPN, HR/SD</p>
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147	09/13/2015

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K 147	<p>Continued From page 15</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2</p> <p>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 National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-three (53).</p> <p>The findings include:</p> <p>1. Observation, on 07/30/15 at 9:58 AM, with the General Contractor revealed a fan plugged into an extension cord located in Room #27.</p> <p>Interview, on 07/30/15 at 9:59 AM, with the General Contractor revealed he was not aware the fan was plugged into an extension cord.</p> <p>2. Observation, on 07/30/15 at 10:17 AM, with the General Contractor revealed a Bi-pap machine was plugged into a power strip located in Room #12.</p> <p>Interview, on 07/30/15 at 10:18 AM, with the General Contractor revealed he was not aware the Bi-pap was plugged into the power strip.</p> <p>The census of fifty-three (53) was verified by the Administrator on 07/30/15. The findings were</p>	K 147	<p>9.1.2</p> <ol style="list-style-type: none"> 1. The Maintenance Contractor removed the extension cords in room #27 & room #32 on 08/01/2015. 2. The Environmental Supervisor will audit the facility weekly for a period of twelve (12) to ensure extension cords are not utilized. 3. The weekly inspection report will be given to the Administrator, who will report the findings to the Quality Assurance Committee monthly for a period of twelve (12) months. 4. The Environmental Supervisor will monitor and be responsible for follow-up and recommendations from the Quality Assurance Committee. 5. Quality Assurance Committee members are as follows: Dr. Amelia Kiser, Medical Director Lisa Wright, LPN, Pharmacy Consultant Yvonne W. Cook, Administrator Tonia Bullock, RN, DON Tammy London, RN, ADON Vivian Kinslow, RSC Sharon Bragg, CDM Shirley James, Environmental Supervisor Sheri Likens, LPN, HR/SD <p>09/13/2015</p>

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K 147

Continued From page 16
acknowledged by the Administrator and verified by the General Contractor at the exit interview on 07/30/15.

K 147

Actual NFPA Standard:

Reference: NFPA 101 (2000 Edition)

9.1.2 Electric.

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

Reference: NFPA 70 (1999 Edition) 400-8 (Extensions Cords) Uses Not Permitted.

Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:

- (1) As a substitute for the fixed wiring of a structure
- (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors
- (3) Where run through doorways, windows, or similar openings
- (4) Where attached to building surfaces

Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) 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.