

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

PRINTED: 01/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/13/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 280 Continued From page 1 toward other residents.

The findings include:

An interview with the Charge Nurse, on 01/12/12 at 2:30 PM, revealed the facility did not have a policy/procedure for the development or revision of a care plan, and stated the facility followed the Resident Assessment Instrument (RAI) Manual.

A record review revealed Resident #1 was admitted to the facility on 07/08/10 with diagnosis to include Schizophrenia.

A review of the Comprehensive Care Plan, dated 07/20/10, revealed the resident had mood and behavior problems as evidenced by being socially inappropriate (yelling out) and resistive to care. Additional review of the Comprehensive Care Plan revealed revisions were made, on 08/31/11, for the resident's acts of verbal/physical abuse toward the staff and for wandering.

A review of the nurses' notes, dated 09/08/11 at 10:00 AM, revealed Resident #1 slapped another resident on the hand when the resident extended his/her hand to Resident #1 to say "good morning."

A review of a Significant Change Minimum Data Set (MDS) assessment, dated 09/09/11, revealed the resident had physically aggressive behaviors toward others and the resident put others at significant risk for physical injury.

A review of the nurses' notes, revealed Resident #1 hit another resident between the area of the mouth and nose with the back of his/her hand on

F 280 *This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.*

Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.

interventions put in place were updated timely on the care plans and remain effective. Results will be presented to facility QA committee no less than quarterly x 12 months.

5.Completion Date 2-2-12

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F 280	<p>Continued From page 2</p> <p>09/16/11. Further review of the nurses' notes revealed, on 10/29/11 at 12:30 PM, Resident #1 was wheeling through the lobby and back-handed another resident.</p> <p>Further record review revealed the Comprehensive Care Plan was not revised to include the aggressive behaviors toward other residents, which occurred on 09/08/11, on 09/16/11, and on 10/29/11.</p> <p>Interviews with Licensed Practical Nurse (LPN) #1, the MDS Coordinator, the Social Worker and the Charge Nurse, on 01/12/12 at 8:55 AM, 10:05 AM, 11:20 AM and 2:30 PM, respectively, and with the Director of Nursing (DON), on 01/13/12 at 1:00 PM, revealed the care plan should have been revised by the MDS Coordinator, on 09/09/11, and the nurses should have revised the care plan, on 09/16/11 and on 10/29/11.</p> <p>F 323 483.25(h) FREE OF ACCIDENT SS=D HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide adequate supervision for one resident (#1), in the selected</p>	F 280	<p><i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i></p> <p><i>Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</i></p> <p><i>To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.</i></p> <p>F - 323</p> <p>1. Resident #1 was discharged from facility on 12-20-11.</p> <p>2. Behavior reports and Report sheets over past month were reviewed by DON and SSD on 2-1-12 to determine if any residents were exhibiting physically aggressive behaviors and to ensure appropriate interventions were placed timely and remain effective</p> <p>3. Beginning 2-6-12, DON will re-educate all nursing staff on managing aggressive behavior by residents. The DON will include in this education resident to resident behavior, and resident to staff behavior. This re-education will be completed by 2-7-12. Beginning 2-6-12 the following actions will occur when</p>

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F 323	<p>Continued From page 3</p> <p>sample of three residents, to prevent Resident #1 from striking out at other residents. Resident #1 was placed on one to one supervision, on 09/08/11, after striking out at another resident. The resident's medications were changed due to his/her behavior; and the resident was taken off one to one supervision, on 09/09/11. One week later, on 09/16/11, Resident #1 hit another resident. Additionally, on 12/07/11, Resident #1 hit a resident and was placed on one to one supervision. Resident #1 was taken off one to one supervision two days later, on 12/09/11, even though the facility was attempting to find placement at another facility due to his/her behaviors, and on 12/14/11, Resident #1 hit another resident.</p> <p>The findings include:</p> <p>An interview with the Charge Nurse, on 01/12/12 at 8:50 AM, revealed the facility had no policy/procedure to address one to one supervision.</p> <p>A record review revealed Resident #1 was admitted to the facility on 07/08/10 with diagnosis to include Schizophrenia.</p> <p>A review of the Comprehensive Care Plan, dated 07/20/10, revealed the resident had mood and behavior problems as evidenced by being socially inappropriate (yelling out) and resistive to care. Additional review of the Comprehensive Care Plan revealed revisions were made, on 08/31/11, for the resident's acts of verbal/physical abuse toward the staff and for wandering.</p> <p>A review of the nurses' notes, dated 09/08/11 at</p>	F 323	<p><i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i></p> <p><i>Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</i></p> <p><i>To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.</i></p> <p>a resident exhibits aggressive behavior towards another resident or staff. The resident will be removed from the situation with safety of residents and staff to be maintained, the nurse in charge is to notify the DON and Administrator of the behavior. The MD is to be notified and the family is to be notified. The nurse in charge will review the care plan and determine if there are measures to put in place that will allow the resident to remain in the facility until the resident can be assessed by DON, Administrator, Social Services or MD. Interventions may include increased supervision, a</p>

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F 323 Continued From page 4

10:00 AM, revealed Resident #1 slapped another resident on the hand when the resident extended his/her hand to Resident #1 to say "good morning." Resident #1 was placed on one to one supervision and a psychiatric consult was requested.

A review of a physician's order, dated 09/09/11, revealed "Risperdal Consta 12.5 milligrams (mg) intramuscular (IM) every two weeks and Risperdal 0.25 mg by mouth (po) two times a day (BID) for two weeks." A review of the nurses' notes, dated 09/09/11 at 8:00 AM, revealed Resident #1 was no longer on one to one supervision even though the resident's medication regimen was changed that day.

An interview with the Director of Nursing (DON), dated 01/13/12 at 1:00 PM, revealed one to one supervision was discontinued for Resident #1 because there were no further incidents of aggressive behavior in 24 hours, and they did not think Resident #1 would strike another resident again.

A review of the nurses' notes, revealed Resident #1 hit another resident between the area of the mouth and nose with the back of his/her hand on 09/16/11 at 6:20 PM.

A review of the nurses' notes, dated 12/07/11 at 2:30 PM, revealed Resident #1 hit another resident when he/she accidentally stepped on Resident #1's foot. Resident #1 was placed on one to one supervision for two days. However, a review of a physician's order, dated 12/09/11, revealed to discharge Resident #1 when other placement was available.

F 323

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move to a private room, medication if ordered by MD, a private sitter or family art bedside. The DON, Administrator, Social Services or the residents MD will assess the resident within 24 hours and determine if the resident presents an acute threat to self, or others. If the assessment indicates that the resident is an acute threat to self or others, the resident will be transferred out of the facility and not re-admitted until it is determined that the resident is no longer an acute threat to self or others. If the resident is assessed as not being an acute threat to self or others, a care plan meeting will be held to review interventions that

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F 323	<p>Continued From page 5</p> <p>An interview with the DON, on 01/13/12 at 1:00 PM, revealed revealed the one to one supervision was discontinued for Resident #1 due to the resident not having any more aggressive behaviors.</p> <p>Further review of the nurses' notes, dated 12/14/11 at 9:30 AM, revealed Resident #1 hit another resident on the arm. Resident #1 was placed on one to one supervision at that time until discharged on 12/20/11.</p> <p>A review of the Social Workers' notes, dated 12/09/11 through 12/20/11, revealed she was actively seeking placement for Resident #1 due to the aggressive behaviors toward other residents.</p> <p>An interview with the Social Worker, on 01/12/12 at 8:55 AM, revealed the facility was seeking placement for Resident #1 due to the aggressive behaviors toward other residents in the facility. She stated the physician wrote an order to discharge the resident as soon as placement could be found. She revealed she contacted facilities that cared for residents with behaviors.</p> <p>An interview with the Licensed Practical Nurse (LPN) Charge Nurse, LPN #1, LPN #2 and LPN #3, on 01/12/12 at 8:50 AM, 11:20 AM, 2:10 PM and 3:05 PM, respectively, revealed residents were placed on one to one supervision when they become a danger to themselves or others. They stated the DON decided when a resident was removed from one to one supervision.</p> <p>An interview with the DON, on 01/13/12 at 1:00 PM, revealed the facility had no exact process</p>	F 323	<p><i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i></p> <p><i>Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</i></p> <p><i>To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction:</i></p> <p>may be put in place to allow the resident to remain in the facility. These may include, but are not limited to, increased supervision, referral to psychiatric services, medication adjustments, behavioral modification interventions. The care plan will be reviewed along with the resident behavior daily for 5 days, then no less than weekly for 4 weeks to ensure the interventions in place are effective and the behavior is managed. After 4 weeks the care plan and resident behavior will be monitored monthly for 3 months by Social Services. A resident with ongoing aggressive behaviors that are not manageable in the facility will be</p>

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	<p>F 323 Continued From page 6 when it came to one to one supervision. She stated the nurses should place a resident on one to one supervision when he/she exhibited behaviors that indicated they were a danger to themselves or others. She revealed the resident was discussed in the morning meetings, and if there was no further aggressive behavior noted, then the one to one supervision was discontinued.</p>	<p>F 323</p>	<p><i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i> <i>Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</i> <i>To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.</i></p> <hr/> <p>given a Notice of Discharge. 4.SSD will review behavior reports daily for physically aggressive behaviors and ensure all interventions were placed appropriately and timely. DON will review report sheets daily for physically aggressive behaviors and report findings to SSD. SSD will report findings to facility QA committee no less than quarterly x6months. Facility QA Committee will review all reports of aggressive behavior by residents to ensure that the above noted procedure is followed for each incident. 5.Completion Date: 2-8-12</p>