

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185093	(X2) MULTIPLE CONSTRUCTION	RECEIVED JAN 18 2013 12/20/2012	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____		B. WING _____

NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, GLASGOW	STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD GLASGOW, KY 42441	Division of Health Care Southern Enforcement Branch
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F 000	INITIAL COMMENTS	F 000	This plan of correction is submitted as required under the State and Federal law. The facility's submission of the Plan of Correction does not constitute as admission on the part of the facility that the findings constitute deficiency, or that the scope and severity determination is correct.	
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 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.  (c) Linens	F 441	NHC of Glasgow does have 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.  1) Resident's #6 & #7 found to have no adverse side effect identified. Inservice I-on-1 with RN #1 on infection control policy with emphasis on glove usage and when to change gloves.  2) Observation during skin assessment's revealed no break in glove technique.  3) Re-inservice of nursing on glove usage policy and procedure. Random monitoring during procedures to ensure compliance.  4) Quality assurance monthly x3 or as directed by UR committee of 5 skin assessments by nursing supervisors. DON will monitor compliance.	1/15/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emogene C. Stephens TITLE: adm (X6) DATE: 1-17-13

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

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

PRINTED: 01/09/2013  
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, GLASGOW</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>109 HOMEWOOD BLVD. GLASGOW, KY 42141</b>	
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F 441	<p>Continued From page 1</p> <p>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 a review of the facility's policies and procedures, it was determined the facility failed to ensure licensed staff washed their hands and changed gloves as required to help prevent the spread and transmission of disease when providing care to two of twenty-seven residents (Residents #6 and #7). Staff failed to remove gloves, wash their hands, and apply clean gloves after contact with Resident #6 and #7's perineum/rectal areas and prior to the continued examination of the resident's back, upper extremities, and abdomen.</p> <p>The findings include:</p> <p>A review of the facility's policies and procedures from their Infection Control Manual, Section: Transmission-Based Procedures, Subject: Glove Technique (Clean), Section Number 707, Original Date December 1998, revised on 10/01/08, revealed the use of gloves was to protect both the patient and health care personnel from exposure to infectious material that may be carried on hands and gloves. The policy also addressed the importance of preventing cross-contamination and the recommended procedure for health care personnel to follow when washing their hands and applying and removing gloves during a clean procedure.</p>	F 441	

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F 441	<p>Continued From page 2</p> <p>1. A record review revealed the facility admitted Resident #6 on 01/04/11 with diagnoses including Dementia, Acute Kidney Failure, Esophageal Reflux, Anemia, Hypertension (HTN), Schizophrenia, Pneumonia, and Depression.</p> <p>On 12/19/12 at 10:45 AM the Unit Manager, Registered Nurse (RN) #1, was observed to apply gloves, partially remove Resident #6's incontinence brief and examine the resident's perineal area by touching the area with gloved hands. RN #1 then reapplied the resident's incontinence brief and proceeded to touch the skin of the resident's back and bilateral upper extremities while still wearing the soiled gloves used to examine the resident's perineal area. RN #1 failed to remove gloves, wash her hands, and apply clean gloves after contact with Resident #6's perineal area and prior to the examination of the resident's back and upper extremities.</p> <p>2. A record review revealed the facility admitted Resident #7 on 04/04/10 with diagnoses including Diabetes, HTN, COPD, Vitamin B12 deficiency, Dementia, Arthritis, Colitis, Diverticulitis, and Alzheimer's Disease.</p> <p>On 12/19/12 at 11:30 AM during an observation of a skin assessment of Resident #7, the Unit Manager, RN #1, was observed to wash her hands, apply gloves, partially remove the resident's incontinence brief, and touch the resident's perineum, groin, and rectal areas. RN #1 then reapplied the resident's incontinence brief and proceeded to touch the resident's back, upper extremities, and abdomen while still wearing the gloves used to examine the</p>	F 441		

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F 441	<p>Continued From page 3</p> <p>resident's perineum and rectum. RN #1 failed to remove gloves, wash her hands, and apply clean gloves after contact with Resident #7's perineum, groin, and rectal area and prior to the examination of the resident's back, upper extremities, and abdominal area.</p> <p>An interview conducted on 12/20/12 at 11:15 AM with RN #1 revealed she was knowledgeable of the facility's policies related to proper hand hygiene and gloving techniques. However, RN #1 stated that she was nervous because she was being watched, and forgot to change her gloves and wash her hands in accordance with facility policy during the observation.</p> <p>An interview conducted on 12/20/12 at 2:10 PM with the Director of Nursing (DON) revealed all health care personnel were instructed on policies and procedures related to infection control during their orientation, and nurses were also assigned educational modules throughout the year which covered infection control, as well as skin care issues, to complete.</p>	F 441		
F 456 SS-C	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain essential mechanical equipment in a safe operating condition. The three industrial washing machines</p>	F 456	<p>NHC of Glasgow does maintain all essential mechanical, electrical &amp; patient care equipment in safe operating condition.</p> <p>The policy of maintenance log was reviewed with no changes on 12-20-2012.</p> <p>Inservices began on 12-20-2012 and completed on 1-19-2013 for staff about importance of filing out maintenance requests in the log book timely and to remind maintenance if not checked quickly.</p> <p>QA on timeliness of response to requests x3 months or as directed by UR committee. Monitored by administrator for compliance.</p>	1-19-2013

*Emogene C. Stephens, adm*  
1-24-12

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F 456	<p>Continued From page 4</p> <p>in the laundry area were leaking from the front of each machine with blankets used to absorb the liquid leakage from one machine.</p> <p>The findings include:</p> <p>An interview with the Maintenance Supervisor on 12/20/12 at 4:00 PM, revealed there was no policy/ procedure for general maintenance repairs in the building but the staff knew to notify Maintenance of issues by writing in the maintenance log located at the nurses' desk. He stated he frequently received verbal notifications on a daily basis.</p> <p>Review of the facility document "Maintenance Logs," undated, revealed the logs were used to notify Maintenance of general maintenance and repair needs. The logs were located at the nurses' station, Dietary, Laundry, and Front Desk. Additional review revealed the logs were checked daily and as needed by maintenance staff. In the event of an immediate need, a call was to be placed to the Maintenance Department or on-call maintenance staff.</p> <p>A review of the November 2012 Maintenance Schedule "Laundry Room (Weekly)," dated 08/15/04, revealed checking the washers for leaks was not included on the check list.</p> <p>An observation of the washing machines on 12/20/12 at 8:50 AM, revealed liquid on the machine surface under the closed door of the three machines. Further, a vertical line of white stain under the closed door followed the moisture trail down the front of the machine surface. Additionally, the small washing machine was</p>	F 456		

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F 456	<p>Continued From page 5</p> <p>surrounded on three sides of the machine's base with stacked blankets to absorb the liquid leakage.</p> <p>An interview with the Housekeeping and Laundry Supervisor on 12/20/12 at 8:50 AM, revealed the Maintenance Log had been used to notify the maintenance staff of the leaking machines on 05/16/12, 05/21/12, 05/31/12, 06/13/12, 06/22/12, 06/27/12, and 11/15/12. The Maintenance Log was initiated by the Maintenance Supervisor on 05/16/12, 05/21/12, 05/31/12, 06/13/12, 06/22/12, and 06/27/12. The entries for 05/21/12, 05/31/12, and 06/22/12 had the solution note that parts were ordered.</p> <p>Interview with the Administrator on 12/20/12 at 2:30 PM, revealed it was her responsibility to ensure the Maintenance Supervisor completed work in the laundry area and she inspected the laundry area one time each week.</p>	F 456		
F 465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary environment related to dust, dirt, and unknown substances built up in the laundry room and the residents' refrigerator in the Unit 1 and Unit 2 Dining Room. The laundry</p>	F 465	<p>NHC of Glasgow does provide a safe/functional/sanitary/comfortable environment for our residents.</p> <p>A chart with daily laundry room cleaning assignments has been posted in the laundry to include outside of washers, sink, countertop, eye wash station.</p> <p>Inservice for all laundry/housekeeping personnel was completed 1-24-2013.</p> <p>All other eye wash stations checked and they were clean and compliant.</p> <p>QA to monitor cleaning by laundry personnel will be done weekly x4 weeks and monthly x3 or as directed by UR committee. Monitored by administrator for compliance.</p>	1-24-2013

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F 465	<p>Continued From page 6</p> <p>room was found to be dirty behind the washing machines, above the washing machines, in the sink and countertop area in the washing machine room, the window grating in the dryer room, the pipes above the dryer bodies, and the air vent by the stairway outside the laundry room. In the Unit 1 and Unit 2 Dining Room, the refrigerator holding residents' nutritional supplements had an orange substance on the flat surfaces inside the refrigerator, and the ice machine filter grating had a buildup of dust and dirt.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. A review of the facility's policy/procedure, "Laundry Cleaning Duties," undated, revealed the cleaning responsibilities of laundry staff focused on the spread of bacteria in areas where clean linen was processed or stored.</li> </ol> <p>An interview with the Maintenance Supervisor on 12/19/12 at 8:00 AM, revealed the maintenance staff was responsible for cleaning the area behind the washing machines, the room located behind the dryers that housed the three dryer tumblers/motors/casing, and the room containing the hot water heater. Additional interview on 12/20/12 at 4:00 PM, revealed the facility had no policy/procedure for maintenance cleaning in the laundry area.</p> <p>An interview with the Housekeeping and Laundry Supervisor on 12/20/12 at 8:50 AM, revealed the laundry staff was responsible for general cleaning in the open laundry area but not behind the washers or the pipes in the room behind the dryers. She stated the laundry staff was responsible for cleaning the sink, countertop, and</p>	F 465	<p>NHC of Glasgow does provide a safe/functional/sanitary/comfortable environment for our residents.</p> <p>Areas identified were cleaned by maintenance 1-8-2013. Policy developed for maintenance &amp; laundry personnel to clean in the laundry area.</p> <p>Unit 1 &amp; 2 dining room refrigerator was thoroughly cleaned 12-19-2012. Revised cleaning/defrosting log placed on refrigerator.</p> <p>Audit of other in-house refrigerators were visited &amp; found in compliance and were being cleaned regularly.</p> <p>Revised flow sheets placed in use on 12-19-2012. Team re-looked at in-house policy of refrigerator. Inservice of revised forms began on 12-19-2012. A preventive maintenance and laundry checklist was developed for weekly cleaning of laundry dryers, air vents, pipes, behind washer/dryers, outside of washers, sink, countertop &amp; eye wash station.</p> <p>QA of refrigerator sanitation &amp; safe condition monitor will be done weekly x4 weeks then monthly x3 or as directed by UR committee. In-house 11-7 RN/unit manager will monitor for compliance. DON is responsible for overall compliance.</p> <p>QA of cleaning pipes, dryers, washers, air vents, sink, countertop, &amp; eye wash station in laundry every 3 months x3 or as directed by UR committee. Compliance monitored by administrator for compliance.</p>	1-31-2013

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F 465	<p>Continued From page 7 eyewash station in the washing machine room.</p> <p>An observation of the laundry area on 12/19/12 at 8:00 AM, revealed a thick buildup of crystalized chemicals on the floor behind the washing machines and a loop of blue wire, covered with dirt and dust, hanging from a ceiling pipe behind a washer. The sink and countertop in the washing machine room was soiled with black substances and cluttered with miscellaneous items. The eyewash station was covered with black residue and black smudges over the bowl surface. Further observation revealed the air vent over the folding table and the air vent in the stairwell located in the laundry area had a thick coating of dust and dirt. Observation of the room containing the hot water heater revealed a buildup of thick dust and dirt buildup on the window grating and an unused wall-mounted fan behind the heater.</p> <p>An interview with Housekeeping/Laundry Staff Member #6 on 12/19/12 at 8:45 AM, revealed the laundry staff was responsible for cleaning the dust from the pipes along the ceiling in the open area of the laundry if time allowed. Housekeeping Staff Member #6 stated there was not an assignment sheet (or cleaning log) for the cleaning responsibilities. She stated the Housekeeping Supervisor had been sick recently and the Facility Administrator was the person in charge of the laundry when the Housekeeping Supervisor was out.</p> <p>2. Observation conducted on 12/19/12 at 9:25 AM of the residents' refrigerator located in the Unit 1 and Unit 2 Dining Room, revealed a sticky, orange substance over one-third of the flat</p>	F 465		

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F 465	<p>Continued From page 8</p> <p>surfaces inside the refrigerator. There was no cleaning schedule or signature log visible on the machine. Additional observation in the dining room revealed the grating over the air filter on the ice machine had dust and dirt buildup on the grating with no cleaning schedule or signature log visible on the machine.</p> <p>An interview with Housekeeping Staff Member #3 on 12/19/12 at 9:45 AM, revealed the nurses on Unit 1 were responsible for cleaning the refrigerator and the housekeeping staff was responsible for cleaning the ice machine. She stated a log was not maintained for cleaning the ice machine.</p> <p>Interview with Registered Nurse (RN) #1 on 12/19/12 at 9:55 AM, revealed the Unit 1 nurse or nursing assistant on the 11:00 PM to 7:00 AM shift was responsible to clean the refrigerator in the dining room and it was a routine part of the cleaning assignment for that shift.</p> <p>An interview with the Unit 1 Manager (RN #4) on 12/20/12 at 9:15 AM revealed the Unit 1 staff was responsible for cleaning the refrigerator in the dining room between Units 1 and #2. The Unit Manager, RN #4, stated the refrigerator was used for nutritional supplements for the residents and should be cleaned every night. She stated the nursing assistant on the 11:00 PM to 7:00 AM shift was responsible for cleaning the refrigerator but the task was not listed on the cleaning assignment sheet and there was no log to indicate the cleaning was done. RN #4, in her role as Manager of Unit 1, stated she was responsible to ensure the work was completed.</p>	F 465		
F 468	483.70(h)(3) CORRIDORS HAVE FIRMLY	F 468		

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F 468 SS-E	<p>Continued From page 9</p> <p><b>SECURED HANDRAILS</b></p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure handrails in the facility were firmly secured in the corridors. During the survey conducted on 12/18/12, 12/19/12, and 12/20/12, handrails were observed to be loose on all resident hallways.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Handrail Maintenance," undated, revealed handrails were to be checked and tightened quarterly, or at any time staff identified an issue, and maintenance staff was to be notified via the maintenance log book.</p> <p>Observations during environmental tour on 12/19/12 between 9:25 AM and 11:00 AM, revealed one loose handrail on Unit 1, four loose handrails on Unit 2, three loose handrails in the coridor outside of the Chapel, eleven loose handrails on Unit 3, and five loose handrails on Unit 4. The handrails continued to be loose throughout the survey ending on 12/20/12.</p> <p>Interview with the Maintenance Supervisor on 12/20/12 at 4:15 PM, revealed the maintenance staff was responsible for tightening the handrails and routinely checked them one time each month. He stated staff was also to inform the</p>	F 468	<p>NHC of Glasgow does provide secure handrails for the residents on each side of the corridor. Policy for handrail maintenance reviewed and updated.</p> <p>All loose rails were removed and repaired with new anchors by maintenance departments.</p> <p>Inservice for all departments on proper reporting and using maintenance log was done by maintenance supervisor and nursing supervisors.</p> <p>Monthly check will be conducted by maintenance x3 months then quarterly.</p>	1-24-2013

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F 468	Continued From page 10 maintenance staff of loose rails verbally and by use of the maintenance log book located at each nurses' desk. The Maintenance Supervisor stated maintenance staff reviewed the log books on a daily basis. According to the Maintenance Supervisor, he was unaware of the loose handrails prior to the tour with the surveyor.	F 468		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a pest control program was effective. Residents on Unit 4 complained of mice and a mouse was observed trapped on a sticky board in a resident room.  The findings include:  A review of the facility's policy for "Pest Control," undated, revealed the facility maintained a contract with a pest control vendor who made monthly and as needed visits.  A review of an agreement with a pest control service dated 10/01/08, revealed monthly service would be provided and included the control of "General Pest (roaches, ants, crickets)" and "Rodent Control." Further review of the monthly invoices from the pest control service for July 2012 through December 2012 revealed the	F 469	NHC of Glasgow has and maintains an effective pest control program. Pest control company has been notified to include rodent control to their monthly visits.  Maintenance supervisor will speak at the next scheduled resident council meeting to encourage residents to report any signs of mice to the staff.  QA monthly x3 or as directed by UR committee to ensure effectiveness of pest program. Monitored by maintenance supervisor for compliance.	1-17-2013

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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, GLASGOW		STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. 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 469	<p>Continued From page 11</p> <p>targeted pest on each visit was "General Pest."</p> <p>The resident group interview on 12/18/12 at 2:00 PM, revealed residents on Unit 4 had recently observed mice in the facility.</p> <p>An observation on 12/19/12 at 10:25 AM, revealed a live mouse caught in a sticky trap in resident room 103 on Unit 3.</p> <p>An interview with the owner of the contracted pest control company on 12/20/12 at 8:37 AM, revealed the service provided to the facility was preventative treatment unless the facility notified the company of a specific problem. He stated the facility had not contacted the company about a rodent problem since the summer months when the company treated the facility for mice in the kitchen.</p> <p>An interview with the Maintenance Supervisor on 12/20/12 at 4:00 PM, revealed he was aware of mice on all resident units and had purchased sticky traps from a local hardware store in an attempt to eliminate the mice. The Maintenance Supervisor acknowledged the contracted pest control company had not been notified of the rodent problem because the sticky traps he purchased were the same thing the pest control company used.</p>	F 469		

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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, GLASGOW			STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. 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: 1968, 1976</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (211)</p> <p>SMOKE COMPARTMENTS: Ten smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was initiated on 12/19/12 and concluded on 12/20/12. NHC Healthcare, Glasgow was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for 194 beds with a census of 174 on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>This plan of correction is submitted as required under the State and Federal law. The facility's submission of the Plan of Correction does not constitute as admission on the part of the facility that the findings constitute deficiency, or that the scope and severity determination is correct.</p>		

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

TITLE

(X6) DATE

*Emogene C. Stephens*

*adm*

1-17-13

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

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K 000	Continued From page 1	K 000		
K 025 SS-D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect three of ten smoke compartments, residents, staff, and visitors. The facility has 194 certified beds with a census of 174 on the day of the survey.</p> <p>The findings include:</p> <p>Observations on 12/19/12 between 11:00 AM and 12:30 PM, with the Director of Plant Operations revealed a smoke partition extending above the ceiling located in Station 2 Long Hall and Station 2 Short Hall. Station 2 Long Hall had a</p>	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185093	(C2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(C3) DATE SURVEY COMPLETED  12/20/2012
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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, GLASGOW	STREET ADDRESS, CITY, STATE, ZIP CODE 101 HOMEWOOD BLVD. GLASGOW, KY 42141
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K 025	<p>Continued From page 2</p> <p>penetration around the main sprinkler pipe. Station 2 Short Hall had a one-inch penetration in the wall and a sleeve for wires that was not sealed to the wall. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview on 12/19/12 between 11:00 AM and 12:30 PM, with the Director of Plant Operations revealed he was not aware of the penetrations in the smoke partition.</p> <p>Interview on 12/20/12 at 10:58 AM, with the Administrator revealed she was aware of the requirements for smoke barriers but not aware of the penetrations in the smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol>	K 025	<p>On 1-7-2013, the penetration on station 2 long hall and short hall were repaired using 3M fire barrier water tight sealant.</p> <p>Inservice for maintenace staff on policy for checking penetrations was done on 1-7-2013.</p> <p>The maintenance director checked the smoke barrier walls throughout the building and found no other penetrations.</p> <p>NHC does provide smoke barriers that are constructed to provide at least a one half hour fire resistance rating in accordance with codes.</p>	1-7-2013
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K 025	Continued From page 3 (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect five of ten smoke compartments, residents, staff, and visitors. The facility is certified for 194 beds with a census of 174 on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 12/20/12 between 8:00 AM and 10:30 AM, with the Director of Plant Operations revealed the cross-corridor doors located in Station 2 Short Hall, Station 2 Long Hall, Cross</p>	K 027		

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K 027	<p>Continued From page 4</p> <p>Hall Doors, and Station 1 Long Hall would not close completely when tested. This was due to the doors not having a coordinator to ensure the door without the t-astragal would close first after the initial close.</p> <p>Interview on 12/20/12 between 8:00 AM and 10:30 AM with the Director of Plant Operations revealed he was unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p> <p>Interview on 12/20/12 at 11:07 AM, with the Administrator revealed she was unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p> <p>NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition).</p> <p>2-4.1 Closing Devices.                  2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.</p>	K 027	<p>The coordinators were ordered on 1-7-2013 and will be installed by contractor.</p> <p>Inserviced staff on proper closing of doors and to place the concerns in the logs.</p> <p>Monthly check by maintenance staff to report to UR monthly x3 or as directed by UR committee.</p>	1-31-2013
K 029 SS-D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185093	(02) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(03) DATE SURVEY COMPLETED  12/20/2012
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K 029	<p>Continued From page 5</p> <p>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 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three of ten smoke compartments, residents, staff, and visitors. The facility is certified for 194 beds with a census of 174 on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas.</p> <p>The findings include:</p> <p>Observation on 12/19/12 between 11:00 AM and 4:30 PM with the Director of Plant Operations revealed rooms to have hazardous storage that did not have a self-closing device to keep the door closed. The hazardous rooms identified were the Payroll Office, the Service Hall Janitors Closet, and the Activities Storage Room.</p> <p>Interview on 12/19/12 between 11:00 AM and 4:30 PM, with the Director of Plant Operations revealed he was not aware the doors to these rooms were required to be self-closing.</p>	K 029	<p>NHC is a one hour fire rated building with a 1/2 hour fire rated doors and is protected by an approved automatic fire extinguishing system.</p> <p>Inserviced staff about keeping doors closed.</p> <p>The self-closing devices were ordered on 1-7-2013 and will be installed by the contractor.</p> <p>Monthly check by maintenance staff and reported to UR committee.</p>	1-31-2013

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K 029	Continued From page 6  Interview on 12/20/12 at 11:01 AM, with the Administrator revealed she was not aware the doors to these rooms were required to be self-closing.  8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.  Reference: NFPA 101 (2000 Edition).  19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities	K 029		

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K 029	Continued From page 7 deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect six of ten smoke compartments, residents, staff, and visitors. The facility is certified for 194 beds with a census of 174 on the day of the survey.  The findings include:  Observation on 12/19/12 between 2:00 PM and 4:30 PM, with the Director of Plant Operations revealed exterior exits with only one light bulb outside to light the egress path. The exits with only one light were identified as Exits 1, 5, 7, 8, 9,	K 045	NHC of Glasgow does provide illumination of means of egress.  Maintenance will check weekly for functioning of outside light bulbs.  Hubbell compact LED wallpack lights for the six exits have been purchased and will be installed by electrical contractor.	1-31-2013

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K 045	<p>Continued From page 8 and 10.</p> <p>Interview on 12/19/12 between 2:00 PM and 4:30 PM, with the Director of Plant Operations revealed he was not aware the exits did not have the required illumination for egress lighting.</p> <p>Interview on 12/20/12 at 11:19 AM, with the Administrator revealed she was not aware of the requirements for egress lighting.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to</p>	K 045		

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K 045	Continued From page 9 the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded	K 050		

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

PRINTED: 01/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/20/2012
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, GLASGOW			STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. 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 050	Continued From page 10 announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect ten of ten smoke compartments, residents, staff, and visitors. The facility is certified for 194 beds with a census of 174 on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times.  The findings include:  Fire Drill review on 12/19/12 at 1:49 PM, with the Director of Plant Operations revealed the facility failed to conduct fire drills at unexpected times on all shifts.  Interview on 12/19/12 at 1:49 PM, with the Director of Plant Operations revealed he was not aware the fire drills were not being conducted as required.  Interview on 12/20/12 at 10:50 AM, with the Administrator revealed she was not aware of the requirements for conducting fire drills.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	NHC of Glasgow does conduct fire drills at unexpected times under varying conditions at least quarterly on each shift. The person conducting the drills will conduct the drills at various hours during each shift.  January fire drills have been at various times.  QA monthly x3 or as directed by UR committee to ensure drills are conducted at unexpected times on each shift. Administrator will monitor for compliance.	1-31-2013

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K 050	Continued From page 11  Reference: NFPA 101 Life Safety Code (2000 Edition). 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050			
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that fire extinguishers were maintained in accordance with NFPA standards. The deficiency had the potential to affect residents, staff, and visitors. The facility has 194 certified beds with a census of 174 on the day of the survey.	K 064	NHC of Glasgow does provide portable extinguishers for this facility.  Fire extinguisher was bought and placed on pavilion (smoking area).	1-4-2013	

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K 064	<p>Continued From page 12</p> <p>The findings include:</p> <p>Observation on 12/20/12 at 9:25 AM, with the Director of Plant Operations revealed there was no fire extinguisher located in the designated employee smoking area.</p> <p>Interview on 12/20/12 at 9:25 AM, with the Director of Plant Operations revealed he was not aware that a fire extinguisher was required to be located in the smoking area.</p> <p>Interview on 12/20/12 at 11:20 AM, with the Administrator revealed she had just not considered having a fire extinguisher installed in the employee smoking area.</p> <p>Reference: NFPA 10 (1999 Edition).</p> <p>4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) *Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place</p> <p>4-3.3 Corrective Action. When an inspection of any fire extinguisher</p>	K 064		

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K 064	Continued From page 13 reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.	K 064		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cooking facilities were protected in accordance with NFPA standards. The deficiency had the potential to affect one of ten smoke compartments, residents, staff, and visitors. The facility is certified for 194 beds with a census of 174 on the day of the survey.  The findings include:  Observation on 12/19/12 at 2:25 PM, with the Director of Plant Operations revealed the steamer and oven were in use while the vent hood was turned off.  Interview on 12/19/12 at 2:25 PM, with the Director of Plant Operations revealed the kitchen hood was required to be turned on any time cooking equipment was in use.  Interview on 12/20/12 at 11:18 AM, with the Administrator revealed she was aware the hood was to be turned on when the cooking equipment was in use, but was not aware they had been turning the hood off while the cooking equipment was still in use.	K 069	Cooking facilities are protected in accordance with 9.2.3  The exhaust fan will be turned on at the beginning of AM shift and remain on until the end of evening shift. Exhaust fan will be left on throughout the cooking process.  The food service director inserviced all dietary staff regarding exhaust fan procedure on 12-20-2012 and 12-21-2012.  QA will be conducted utilizing weekly checks to ensure exhaust fan is operating throughout cooking process. This will be conducted x3 months or as directed by UR committee. The dietitian and dietary manager will monitor this study for compliance.	1-10-2013

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K 069	Continued From page 14 Reference: NFPA 101 (2000 Edition).  19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3. Exception*: Where domestic cooking equipment is used for food-warming or limited cooking, protection or segregation of food preparation facilities shall not be required.  9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.  Reference: NFPA 96  11.4 Cleaning of Exhaust Systems. 11.4.1 Upon inspection, if found to be contaminated with deposits from grease-laden vapors, the entire exhaust system shall be cleaned by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Section 11.3. 11.4.2* Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal prior to surfaces becoming heavily contaminated with grease or oily sludge. 11.4.3 At the start of the cleaning process, electrical switches that could be activated accidentally shall be locked out. 11.4.4 Components of the fire suppression system shall not be rendered inoperable during	K 069			

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K 069	<p>Continued From page 15</p> <p>the cleaning process.</p> <p>11.4.5 Fire-extinguishing systems shall be permitted to be rendered inoperable during the cleaning process where serviced by properly trained and qualified persons in accordance with Section 11.3.</p> <p>11.4.6 Flammable solvents or other flammable cleaning aids shall not be used.</p> <p>11.4.7 Cleaning chemicals shall not be applied on fusible links or other detection devices of the automatic extinguishing system.</p> <p>11.4.8 After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance.</p> <p>11.4.9 All access panels (doors) and cover plates shall be replaced.</p> <p>11.4.10 Dampers and diffusers shall be positioned for proper airflow.</p> <p>11.4.11 When cleaning procedures are completed, all electrical switches and system components shall be returned to an operable state.</p> <p>11.4.12 When a vent cleaning service is used, a certificate showing date of inspection or cleaning shall be maintained on the premises.</p> <p>11.4.13 After cleaning is completed, the vent cleaning contractor shall place or display within the kitchen area a label indicating the date cleaned and the name of the servicing company, and areas not cleaned.</p> <p>11.4.14 Where required, certificates of inspection and cleaning shall be submitted to the authority having jurisdiction.</p> <p>Reference: NFPA 96</p> <p>11.3 Inspection of Exhaust Systems. The entire exhaust system shall be inspected by</p>	K 069			

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K 069	Continued From page 16 a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Table 11.3.  Table 11.3 Exhaust System Inspection Schedule Type or Volume of Cooking Frequency - Frequency Systems serving solid fuel cooking operations - Monthly Systems serving high-volume cooking operations such as 24-hour cooking, charbroiling, or wok cooking - Quarterly Systems serving moderate-volume cooking operations - Semiannually Systems serving low-volume cooking operations, such as churches, day camps, seasonal businesses, or senior centers - Annually  Reference: NFPA 96 (1998 Edition).  7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.	K 069		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 070		

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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, GLASGOW	STREET ADDRESS, CITY, STATE, ZIP CODE 169 HONORWOOD BLVD. GLASGOW, KY 42144
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K 070	<p>Continued From page 17</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by. Based on observation and interview it was determined the facility failed to ensure portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect two of ten smoke compartments, residents, staff, and visitors. The facility is certified for 194 beds with a census of 174 on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 12/19/12 between 11:00 AM and 4:30 PM with the Director of Plant Operations revealed portable space heaters located in the Dietary Manager's Office, Infection Control Office, Social Services Office, and Central Supply. Further observation revealed a fireplace with a heating unit was located in room 152. The facility did not have a policy for portable heaters or documentation that the heaters did not exceed 212 degrees.</p> <p>Interview on 12/19/12 between 11:00 AM and 4:30 PM with the Director of Plant Operations revealed he was not aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas; he thought this requirement was only for patient care areas.</p>	K 070	<p>Staff inserviced about no use of heaters – heaters removed.</p> <p>Maintenance to check weekly to ensure that no heaters are used in patient areas or offices.</p> <p>Reported to UR monthly.</p>	1-31-2013
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K 070	Continued From page 18  Interview on 12/20/12 at 11:10 AM with the Administrator revealed she was not aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas; she thought this requirement was only for patient care areas.  Reference: NFPA 101 (2000 Edition).  19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).  K 075 SS=D NFPA 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 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 trash collection receptacles with capacities greater than	K 070	Soiled linen or trash collection receptacles were moved outside building.  Inservice was conducted for all housekeeping/laundry & maintenance staff as to ensure carts not left in corridor unattended.  QA monthly x3 or as directed by UR committee to ensure staff is following policy. Administrator will monitor for compliance.	1-24-2013

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K 075	<p>Continued From page 19</p> <p>32 gallons were stored in accordance with NFPA standards. The deficiency had the potential to affect one of ten smoke compartments, residents, staff, and visitors. The facility is certified for 194 beds with a census of 174 on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 12/20/12 at 10:21 AM with the Director of Plant Operations revealed two trash carts and a linen cart with capacities over 32 gallons that were left unattended in the Laundry Exit corridor.</p> <p>Interview on 12/20/12 at 10:21 AM, with the Director of Plant Operations revealed he was unaware the staff would leave the carts in the corridor unattended.</p> <p>Interview on 12/20/12 at 11:15 AM, with the Administrator revealed she was unaware of the requirements for trash receptacles with capacities greater than 32 gallons.</p> <p>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/ft<sup>2</sup> (20.4 L/m<sup>2</sup>). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft<sup>2</sup> (5.9-m<sup>2</sup>) 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>	K 075		

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**K 147 SS-F** NFPA 101 LIFE SAFETY CODE STANDARD

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect nine of ten smoke compartments, residents, staff, and visitors. The facility is certified for 194 beds with a census of 174 on the day of the survey.

The findings include:

Observations on 12/19/12 between 11:00 AM and 4:30 PM, with the Director of Plant Operations revealed:

- 1) Two open electrical junction boxes located in the attic of Station 1 Left.
- 2) Storage in front of electrical panels located in the Transfer Switch Room.
- 3) A refrigerator plugged into a power strip located in the MDS Office.
- 4) Extension cords in use located in rooms 100, 102, 104, 105 106, 119, 123, and 144.
- 5) A refrigerator and microwave plugged into a power strip located in rooms 103 and 104.
- 6) A microwave plugged into a power strip located in room 110.
- 7) A hydrocollator not plugged in to a ground fault protected outlet located in the Physical Therapy

**K 147** NHC of Glasgow has electrical wiring in accordance with NFPA standards.

- 1) Covers were installed on boxes on 1-7-2013.
- 2) Room cleaned of all stored items within 3 feet of electric panel 12-20-2012.
- 3) Devices to be plugged into wall outlet 12-19-2012.
- 4,5,6,8,9,10,11,12,13,14,15,16,17,18,19,20, 21,22) All devices are plugged into wall outlet.
- 7) Inserved PT staff and corrected on 12-19-2012.
- 23&24) Rearranged devices-eliminated use of extension cords.
- 25) Cabinets removed and redesigned on station 1 & station 2 medicine rooms to allow 3 foot clearance.
- 26) Appliances rearranged or sent home to alleviate the use of extension cords. Inservice for resident.

Inservices on 12-20-2012 for all staff on power strips, extension cords and heater use was done by maintenance and supervisors.

QA monthly X3 or as directed by UR committee checking for power strip usage, heaters and extension cords by maintenance supervisor.

3-10-2013

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K 147	Continued From page 21 Room. 8) A power strip plugged into another power strip located in the Station 3 Nurses' Conference Room. 9) A refrigerator plugged into a multi-plug adapter located in room 112. 10) An extension cord plugged into a multi-plug adapter located in room 113. 11) A refrigerator plugged into a power strip located in rooms 115, 127, 129, 135, 157, 16, and Station 2 Med Room. 12) Two power strips and two refrigerators plugged into a multi-plug adapter located in room 128. 13) A refrigerator plugged into a multi-plug adapter located in room 132. 14) A power strip plugged into a multi-plug adapter located in rooms 148 and 154. 15) A refrigerator and a power strip plugged into a multi-plug adapter located in room 149. 16) A microwave plugged into a power strip located in rooms 150 and 152. 17) A bed plugged into a multi-plug adapter located in room 152. 18) A microwave and refrigerator plugged into a power strip located in room 155. 19) Two refrigerators plugged into a multi-plug adapter located in room 156. 20) A power strip plugged into an extension cord located in the Classroom. 21) A microwave plugged into a power strip and a power strip plugged into another power strip located in room 139. 22) A microwave and an extension cord plugged into a power strip located in room 137. 23) An extension cord plugged into a power strip located at the Receptionist Desk in the Front Lobby.	K 147		

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

PRINTED: 01/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/20/2012
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, GLASGOW			STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141		
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K 147	<p>Continued From page 22</p> <p>24) A refrigerator and coffeemaker plugged into a power strip located in the Administrator's Bathroom.</p> <p>25) Storage of built-in cabinets in front of electrical panels located in Station 2 Med Room and Station 1 Med Room.</p> <p>26) An extension cord plugged into a power strip and a power strip plugged into another power strip, and a refrigerator plugged into an extension cord plugged into a power strip located in room 17.</p> <p>Interview on 12/19/12 between 11:00 AM and 4:30 PM, with the Director of Plant Operations revealed he was aware of the proper use of power strips and extension cords but not aware any had been misused.</p> <p>Interview on 12/20/12 at 11:02 AM, with the Administrator revealed she was aware of the proper use of power strips and extension cords but not aware any had been misused.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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.</p> <p>Reference: NFPA 70 400-8.</p> <p>(Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible</p>	K 147			

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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, GLASGOW		STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141		
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K 147	<p>Continued From page 23</p> <p>ords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access</p>	K 147		

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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, GLASGOW			STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141		
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K 147	Continued From page 24 and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147			