

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

PRINTED: 07/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P.O. BOX 189 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 000	<p>INITIAL COMMENTS</p> <p>A standard recertification survey and an abbreviated survey (KY #18577) was conducted on 06/26/12 through 06/28/12 to determine the facility's compliance with Federal requirements. The facility was found to be in substantial compliance with Federal requirements with no deficiencies cited. KY #18577 was substantiated with no deficiencies.</p>	F 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVBY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1967</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Four (4) stories, Type 1 (222)</p> <p>SMOKE COMPARTMENTS: Eighteen (18) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Partial automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/27/12. Glasgow State Nursing Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred (100) beds with a census of eighty-four (84) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulation, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	 <p>POC ACCEPTED</p> <p>JUL 10 2012</p> <p><i>W</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca J. Jansky TITLE: Director (X6) DATE: 7-13-12

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: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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	Continued From page 1	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of eighteen (18) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100)</p>	K 018	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>No residents were affected by the deficient practice.</p> <p>Foam was inserted around the jamb on corridor doors to rooms 410, 407, 406, 209, 206, 204 and 202 to resist the potential passage of smoke on 07/09/12.</p> <p>The resident room doors to rooms 412, 411, 305 and 307 were repaired on 07/11/12 to ensure proper latching.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All corridor doors to residential rooms were inspected on 07/11/12 to ensure the doors did not have too large of a gap to resist the potential passage of smoke as well as being able to latch correctly. Two doors were identified as not latching correctly and were immediately repaired by a maintenance staff member.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Maintenance staff will inspect all corridor doors to residential rooms on a monthly basis to ensure they latch properly and that there are no areas that would not resist the passage of smoke. Repairs will be completed as indicated. The preventative maintenance check will be entered into the facility internal database for tracking and trending by the 25th of the month.</p>	08/03/12

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 018	<p>Continued From Page 2</p> <p>beds with a census of eighty-four (84) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/27/12 between 10:15 AM and 3:00 PM, with the Maintenance Tech III revealed the corridor doors to rooms 410, 407, 406, 209, 206, 204 and 202 had a gap too large around the jamb and would not resist the passage of smoke.</p> <p>Interview, on 06/27/12 between 10:15 AM and 3:00 PM, with the Maintenance Tech III revealed they were not aware of the allowable gap in the corridor doors.</p> <p>Observation, on 06/27/12 between 10:15 AM and 3:00 PM, with the Maintenance Tech III revealed the resident room doors to rooms 412, 411, 305 and 307 did not latch.</p> <p>Interview, on 06/27/12 between 10:15 AM and 3:00 PM, with the Maintenance Tech III revealed they were unaware the doors to the resident rooms did not latch.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 in. (4.4 cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard of Fire Doors and Fire Windows, shall not be required. Clearance between the</p>	K 018	<p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The Life Safety CQI monitor BS-3 for the monitoring of life safety regulations will be utilized monthly under the supervision of the facility director. The CQI monitor includes the criteria "resident room doors have no gaps" and "doors properly latch". Findings of the audit as well as any corrective action steps will be shared at the monthly CQI/QA Committee meeting. The facility director is responsible for reviewing all reports shared at the CQI/QA Committee.</p>	

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 018	Continued From page 3 bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied to the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards. NFPA 101 LIFE SAFETY CODE STANDARD	K 018		
K 025 SS=D	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.	K 025	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the deficient practice. The smoke partitions extending above the ceiling located at the 1 st floor north fire doors, 1 st floor far south fire doors, and the 3 rd floor north fire doors were sealed on 07/09/12. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All smoke compartments were inspected on 07/13/12 with no issues noted.	

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 025	<p>Continued From page 4 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 observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect six (6) of eighteen (18) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of eighty-four (84) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/27/12 between 9:15 AM and 10:15 AM, with the Maintenance Tech III revealed the smoke partitions, extending above the ceiling located at the 1st floor north fire doors, 1st floor far south fire doors, and the 3rd floor north fire doors, were not properly sealed. The barriers failed to be properly sealed from piping and wires.</p> <p>Interview, on 06/27/12 between 9:15 AM and 10:15 AM, with the Maintenance Tech III revealed they were not aware of the penetrations in the smoke barriers.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires,</p>	K 025	<p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Maintenance staff will inspect all smoke compartments on a monthly basis with the results being entered in the facility internal database for tracking by the 25th of the month. If issues are identified with piping or wiring, maintenance staff will promptly apply sealant.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The Life Safety CQI monitor ES-3 for the monitoring of life safety regulations will be utilized monthly under the supervision of the facility director. The CQI monitor includes the fire wall criteria of "any/all penetrations are properly sealed with a fire resistive sealant". Findings of the audit as well as any corrective action steps will be shared at the monthly CQI/QA Committee meeting. The facility director is responsible for reviewing all reports shared at the CQI/QA Committee.</p>	

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 025	Continued From page 5 air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (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 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1-3/4 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	K 027	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the deficient practice. All thirteen cross-corridor doors located throughout the facility were inspected on 07/11/12. All doors closed completely with the exception of 1 st floor north and 4 th floor south. A new coordinator was installed on the 1 st floor north door and 4 th floor south door so they would close completely when tested. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. A door vendor visited the facility on 07/13/12 and reviewed the mechanics of cross-corridor doors with t-astragal with maintenance personnel.	

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 027	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by:</p> <p>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 fifteen (15) of eighteen (18) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of eighty-four (84) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 06/27/12 between 9:15 AM and 10:15 AM, with the Maintenance Tech III revealed the cross-corridor doors located throughout the facility would not close completely when tested. This was due to the doors coordinators being out of adjustment to ensure the door without the t-astagal would close first after the initial close.</p> <p>Interview, on 06/27/12 between 9:15 AM and 10:15 AM, with the Maintenance Tech III revealed they were unaware what the coordinators on the doors were for and therefore did not know how to test them. The doors need a functioning 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>	K 027	<p>Address what measures will be put into place or systemic changes made to ensure that the deficient practices will not recur.</p> <p>All thirteen cross-corridor doors will be inspected monthly by maintenance staff to ensure they close correctly. Any identified concerns will be addressed promptly by maintenance personnel. The preventative maintenance check will be entered into the facility internal database by the 25th of the month.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The Life Safety CQI monitor ES-3 for the monitoring of life safety regulations will be utilized monthly under the supervision of the facility director. The CQI monitor includes the criteria of "cross-corridor doors close completely when tested and coordinators are operational". Findings of the audit as well as any corrective action steps will be shared at the monthly CQI/QA Committee meeting. The facility director is responsible for reviewing all reports shared at the CQI/QA Committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 – MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 027	Continued From page 7 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. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers or grilles.	K 027		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1-1/2 hour duration is provided in accordance with 7.9 19.2.9.1 This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect eighteen (18) of eighteen (18) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of eighty-four (84) on the day of the survey.	K 046	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the deficient practice. Maintenance staff tested all seven emergency lights, with battery backup, located throughout the facility for 1-1/2 hours on 07/09/12. Two emergency lights were operational for 90 minutes, four lights were operational for 60 minutes and one light was not operational at all. Simplex Grinnell installed new batteries in the five emergency lights that were not fully operational for 90 minutes on 07/11/12. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Maintenance staff retested the five emergency lights with new batteries for 90 minutes on 07/12/12. Three of the lights were operational for 90 minutes and two were operational for 70 minutes. Simplex Grinnell installed new batteries on 7/13/12 for the two emergency lights which were not fully operational on 7/12/12.	

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 – MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 GLASGOW, KY 42141	
(X4) ID PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	<p>Continued From page 8</p> <p>The findings include:</p> <p>Observation and record review, on 06/27/12 at 2:30 PM, with the Maintenance Tech III revealed that the emergency lights, with battery backup, located throughout the facility were not tested for 1-1/2 hours within the last year.</p> <p>Interview, on 06/27/12 at 2:30 PM, with the Maintenance Tech III revealed they were unaware the lighting had to be tested annually for 1-1/2 hours.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1-1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, no less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1-1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than</p>	K 046	<p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Maintenance staff will complete a yearly test of 90 minutes of all emergency lights with battery backup. Documentation will be inputted into the facility internal database for tracking and trending.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>A replacement facility for Glasgow State Nursing Facility is in progress with a January 2013 tentative completion date. Testing of the emergency lighting with battery backup will be conducted upon completion of the new facility and annually thereafter.</p> <p>The annual review and testing of emergency lights will be maintained in the maintenance supervisor office and discussed at the January Fire & Safety meeting. The facility director is responsible for reviewing all reports shared at the Fire & Safety meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 046	Continued From page 9 1-1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
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 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect eighteen (18) of eighteen (18) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a	K 050	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All fire drills conducted thus far in 2012 were input into a spreadsheet for easy viewing of times and dates by all maintenance personnel. Sixteen fire drills were conducted from January 1 - June 30, 2012. First shift fire drill times ranged from 10:24am - 2:52pm. Second shift fire drill times ranged from 6:45pm - 10:40pm. Third shift fire drill times ranged from 11:00pm - 6:40am. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 – MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 census eight-four (84) on the day of the survey. The findings include: Fire Drill review, on 06/27/12 at 2:10 PM, with the Maintenance Tech III revealed the fire drills were not being conducted at unexpected times under varied conditions. Second shift drills were being performed predictably between 8:12 PM and 10:19 PM and third shift was being performed at around 11:00 PM. Interview, on 06/27/12 at 2:10 PM, with the Maintenance Tech III revealed they were unaware the fire drills were not being conducted as required. They did reveal the fire drills were hard to keep track of and that the records would be better kept from here on out. 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	Facility Policy SS-400 Fire Plan was revised on 07/12/12 to include "The maintenance department will be responsible for scheduling and conducting monthly fire drills on all three shifts at random times". Documentation of the completed fire drills will be entered into the facility internal database for tracking/trending and will be shared with the Facility Director. The facility director will review the monthly report to ensure drills are not being conducted at the same time from month to month. Indicate how the facility plans to monitor its performance to ensure the solutions are sustained. The CQI monitor ES-6 for the monitoring of fire and evacuation drills will be utilized monthly under the supervision of the facility director. The CQI monitor includes the criteria of "randomly conducting fire drills at varied times". Findings of the audit as well as any corrective action steps will be shared at the monthly CQI/QA Committee meeting. The facility director is responsible for reviewing all reports shared at the CQI/QA Committee.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress in accordance with NFPA standards. The deficiency had the potential to affect six (6) of eighteen (18) smoke	K 130	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Glasgow State Nursing Facility is designated as an Institute for Mental Disease (IMD). All residents admitted to the facility must have a mental illness and/or developmental disability diagnosis. As such, the facility serves a special needs population. The facility is a four story building with the residents residing on floors 2 nd -4 th . The egress doors open to unsecured stairwells.	

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 – MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 130	Continued From page 11 compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of eighty-four (84) on the day of the survey. The findings include: Observation, on 06/27/12 between 9:15 AM and 10:15 AM, with the Maintenance Tech III revealed a lock (slide bolt type) was installed on the egress side of the cross-corridor doors. The doors affected included the 2 nd floor west, 2d floor north, 3 rd floor west, 3 rd floor north, 4 th floor north, and the last 4 th floor south doors. Interview, on 06/27/12 between 9:15 AM and 10:15 AM, with the Maintenance Tech III revealed they were unaware locks could not be placed on the egress side of any gate or door. Reference: NPPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	A door vendor visited the facility on 07/13/12 to evaluate the egress doors and determine if the panic push bars can be manually secured. The vendor recommending installing keyed locks on the panic bars and will forward a proposal by 7/20/12. Once the egress doors have been evaluated and determined if an approved locking mechanism can be utilized to secure the panic bars, the slide bolt locks will be removed from the 2 nd floor west, 2 nd floor north, 3 rd floor north, and 4 th floor north doors. Upon hire, all staff is issued an A1 key for access to the facility and residential units. If the panic bar can be keyed, an A1 core will be used since all state and contract staff has an A1 key. Also, a full staff meeting will be scheduled to in-service all state and contract staff on the expectation and proper procedures for opening the egress doors. A replacement facility for Glasgow State Nursing Facility is in progress with a January 2013 tentative completion date. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The egress doors will be checked on a monthly basis by the 25 th of the month to ensure they are not equipped with a latch or lock on the egress side and that the doors open freely when unlocked with the A1 key. Documentation will be input into the facility internal database for tracking and trending. Indicate how the facility plans to monitor its performance to ensure the solutions are sustained. The Life Safety CQI monitor BS-3 for the monitoring of life safety regulations will be utilized monthly under the supervision of the facility director. The CQI monitor includes the criteria of "no utilization of slide bolts on egress doors". Findings of the audit as well as any corrective action steps will be shared at the monthly CQI/QA Committee meeting. The facility director is responsible for reviewing all reports shared at the CQI/QA Committee.	
K 135 SS=D	NPPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NPPA 30, Flammable and Combustible Liquids Code, and NPPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NPPA 30, Flammable and Combustible Liquids Code, NPPA	K 135		

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 135	<p>Continued From page 12 99. 4.3, 10.7.2.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to properly store flammable and combustible liquids in accordance with NFPA standards. The deficiency had the potential to affect three (3) of eighteen (18) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of eighty-four (84) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/27/12 between 10:15 AM and 3:00 PM, with the Maintenance Tech III revealed cans of flammable aerosol, Lysol, pledge, scented mist and hairspray stored on shelves in the facility. Examples of the storage were the housekeeping closet, receiving closet, receiving storage, and kitchen storage. All flammable materials shall be stored in a flammable proof cabinet if stored in the facility.</p> <p>Interview, on 06/27/12 between 10:15 AM and 3:00 PM, with the Maintenance Tech III revealed they were aware that flammable items could not be stored outside a flammable cabinet but did not know the items were being stored outside of the cabinets.</p> <p>NFPA 99.</p>	K 135	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>No residents were affected by the deficient practice.</p> <p>A NFPA 30 approved cabinet was ordered and received on 07/12/12 to store flammable and combustible liquids. The cabinet is located in the receiving area and all housekeeping, dietary and receiving flammable and combustible liquids have been placed in the cabinet.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>A tour of the facility was conducted on 07/12/12 to ensure all flammable and combustible liquids in the dietary, housekeeping and receiving office were housed in the storage cabinet.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Maintenance personnel will tour the facility monthly to ensure all flammable and combustible liquids are stored in a NFPA 30 approved cabinet. The audit will be entered into the facility internal database for tracking and trending by the 25th of the month.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p>	

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

PRINTED: 07/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2012
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE, P. O. BOX 189 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 135	<p>Continued From page 13</p> <p>10-7.2.1* Flammable and Combustible liquids shall be used from and stored in approved containers in accordance with, NFPA 30- 4.3.3</p> <p>Storage cabinets that meet at least one of the following sets of requirements shall be acceptable for storage of liquids:</p> <p>(a) Storage cabinets that are designed and constructed to limit the internal temperature at the center of the cabinet and 1 in. (25 mm) from the top of the cabinet to not more than 325° F (162.8° C), when subjected to a 10-minute fire test that simulates the fire exposure of the standard time-temperature curve specified in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, shall be acceptable. All joints and seams shall remain tight and the door shall remain securely closed during the test.</p>	K 135	<p>The Life Safety CQI monitor ES-3 for the monitoring of life safety regulations will be utilized monthly under the supervision of the facility director. The CQI monitor includes the criteria of "flammable liquids are properly stored in metal cabinets" and "combustible materials are stored neatly in proper containers". Findings of the audit as well as any corrective action steps will be shared at the monthly CQI/QA Committee meeting. The facility director is responsible for reviewing all reports shared at the CQI/QA Committee.</p>	