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

PRINTED: 08/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185093		08/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, GLASGOW	109 HOMEWOOD BLVD., P O BOX 247 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	INITIAL COMMENTS An annual recertification survey was conducted on 08/10/10 through 08/13/10 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S "D".	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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	**Notify of changes** **NHC of Glasgow does inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a)** **I) 1. Resident #2's (#5099) physician was notified of resident's blood sugar history, specifically low & high readings on 8/12/2010 by the Director of Nursing. New order was received to notify physician for blood sugar readings less than 50 or greater than 450.** **DON reviewed policies with supervisor's #2 and #3 on 8/12/2010.** **2. Center audit conducted with all resident records being reviewed and if not previously notified, the physician was notified of any blood sugar reading <60 or >400 or abnormal signs & symptoms of hyperglycemia or hypoglycemia. New orders were noted as needed. QA completed on 8/12/2010 by DON and Regional Nurse.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emogene C. Stephens	adm	8-31-10

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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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to notify the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status or a need to alter treatment significantly for two residents (#2 and #4) in the selected sample of 28. Resident #2's physician was not contacted when the resident had Accu Check readings below 60. Resident #4's physician was not notified regarding a change in his/her behavior requiring the administration of an as needed (prn) intramuscular (IM) medication. Findings include: 1. Resident #2 was admitted to the facility on 11/30/09 with diagnoses to include Anemia, Diabetes Mellitus, History of Falls, and Senile Dementia. A review of the policy entitled "Insulin Administration" not dated, revealed the physician was to be notified of blood sugars below 60 or above 400 unless there was a specific order addressing blood sugars outside those ranges or directing them otherwise. Specific orders for interventions for blood sugar below sixty would be obtained on an as needed patient specific basis. A review of the physician's orders, dated 12/01/09, revealed an order was obtained stating the physician was to be contacted if the resident's blood sugar was less than 60 milligrams (mg)/deciliter (dL) or greater than 500 mg/dL. Further, review of the resident's Diabetic	F 157	**3. Overseen by the Medical Director, Regional Nurse, and Director of Nursing on 8/12/2010, the center's policies for "Insulin Administration" and "Notification of Physician" were reviewed to direct the nursing staff to notify physician when a resident's blood sugar is <60 or >400 and when the patient is exhibiting abnormal signs of hyperglycemia of hypoglycemia or as directed by the resident's current physician order.** **Overseen by the Director of Nursing on 8/12/2010, Licensed nurses were inserviced on the center's policies for "Insulin Adminstration" & "Notification of Physician". Specific emphasis was given during the inservice on the updated portions of the policies that direct nursing staff to notify the physician when:** **A) A resident's blood sugar is <60 or >400** **B) When the patient is exhibiting abnormal signs of hyperglycemia or hypoglycemia** **C) Or as directed by the resident's current physician order** **4) Overseen by the Director or Nursing, beginning on 8/12/2010, 5 current resident records with orders for blood sugar readings or a history of hyperglycemia or hypoglycemia will be reviewed daily for compliance with the nurse notifying the physician per policy or physician order. These monitors will be continued for 10 days then weekly x6 weeks. Results will be reported to Quality Assurance Committee and the monitors and inservice training will be continued as directed by the QA Committee.**	

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F 157	Continued From page 2 Monitoring Log for February 2010 revealed on 02/17/10 at 12:00 PM, the resident's blood glucose was 56 mg/dL, on 02/20/10 at 7:30 AM, the resident's blood glucose was 57 mg/dL, and on 02/25/10 at 7:30 AM, the resident's blood glucose was 53 mg/dL. The record revealed the resident's physician was not notified of the low blood glucose levels. A review of the physician's orders, dated 02/28/10, revealed an order for notifying the physician for blood sugars less than 60 mg/dL or greater than 500 mg/dL was carried forward and current. A review of the Diabetic Monitoring Log for March 2010 revealed on 03/10/10 at 7:30 AM, the resident's blood glucose was 48 mg/dL and at 12:00 PM, the resident's blood glucose was 54 mg/dL, on 03/14/10 at 7:30 AM, the resident's blood glucose was 57 mg/dL and at 12:00 PM, the resident's blood glucose was 56 mg/dL, on 03/23/10 at 7:30 AM, the resident's blood glucose was 49 mg/dL and on 03/31/10 at 7:30 AM, the resident's blood glucose was 47 mg/dL. The record revealed the resident's physician was not notified of the low blood glucose levels. An interview, on 08/12/10 at 10:20 AM, with the Unit Manager of the 100 hall revealed the nurse should have notified the doctor when the resident had a blood glucose level less than 60 mg/dL. An interview, on 08/12/10 at 10:43 AM, with Licensed Practical Nurse (LPN) #2 revealed she was the nurse who completed the Accu Checks on 02/20/10, 02/25/10, and 03/10/10. She stated the resident was not showing any symptoms of low blood sugar and it was an over-site on her part not contacting the physician about the low blood glucose levels. She stated, "Apparently, I	F 157		

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F 157	Continued From page 3 did not call the doctor or chart it. I should have notified the doctor when the blood glucose level was less than 60 mg/dL and also documented it in the resident's record". An interview, on 08/12/10 at 12:59 PM, with LPN #3 revealed she completed the Accu Checks on 02/17/10, 03/14/10, 03/23/10, and 03/31/10. She stated the incidents were brought to her attention by the Unit Manager because the physician was not notified of the low levels. The LPN stated she did not notify the doctor of the low blood glucose levels obtained. She revealed the resident was not showing any symptoms of low blood glucose. She stated, "I would say, I should have called the doctor with the low blood glucose levels". An interview, on 08/12/10 at 1:45 PM, with the Director of Nursing (DON) revealed the nurses should have notified the physician with each low blood glucose level. She stated, "If the doctor's orders stated to notify the physician with blood glucose levels less that 60, then I expect the nurse to carry out the order". An interview, on 08/12/10 at 2:06 PM, with the Advanced Registered Nurse Practitioner (ARNP) revealed she expected the staff to notify her if the resident's blood glucose level was less than 60 mg/dL. She stated it was the policy of the facility and the staff were expected to follow it. Additionally, the ARNP stated the staff did not call her with the low glucose levels and how the resident was responding. 2. Resident #4 was admitted to the facility on 01/05/10 with diagnoses to include Left side Hemiparesis and Late Effect Cerebral Vascular Accident.	F 157		

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F 157	Continued From page 4 A review of Resident #4's physician orders, dated 07/29/10, revealed an order for Ativan 0.5 intramuscular (IM) every six hours as needed (prn) for anxiety, with a start date of 01/14/10. A review of Resident #4's medication administration record (MAR) , dated February 2010, revealed the resident received the IM medication on 02/11/10 at 4:45 AM for increased anxiety. A review of Resident #4's nurses notes, dated 02/11/10 at 4:30 AM, revealed the resident was in bed "hollering out I've had a stroke. I can't talk." The entry also noted the resident was continuously moving his/her right arm and leg about on the bed. At 4:45 AM the nurses note revealed the resident was given Ativan 0.5 mg IM for increased anxiety. An interview with Licensed Practical Nurse (LPN) #1, on 08/12/10 at 9:15 AM, who administered the IM medication on 02/11/10, revealed she felt the resident's level of anxiety/agitation was worse than usual. LPN #1 revealed the resident had episodes of yelling and screaming out at times but they seemed louder and more intense on 02/11/10. She revealed she did not contact the physician prior to administering the IM medication. An interview with Registered Nurse (RN) #1, on 08/12/10 at 9:35 AM, revealed she assessed Resident #4 the night the IM Ativan was administered and the resident was screaming, yelling, and extremely agitated. An interview with the DON, on 08/12/10 at 1:20 PM, revealed on the night Resident #4 received	F 157	**II) 1.Resident #4's (#5106) physician was contacted and made aware that PRN Ativan IM was given x1 on 2/11/2010. Discussed resident's agitated condition at the time. Unit Manager met with physician & discussed the IM Ativan order. Order discontinued 8/24/2010.** **2. Residents' with an order for IM Ativan Were identified. Records audited on 8/12/2010 with no new findings.** **3. Inservice of nursing supervisors on facility policies regarding PRN medication use & when to call the physician "immediately" with emphasis on significant change in patient status & adequate indication for use. Initial QA was completed on active IM PRN anti-anxiety medications. Findings were discussed at UR committee meeting 8/24/2010 without any changes or recommendations.** **QA will be continued every 2 weeks and reported to UR committee monthly x3 or as directed by UR committee. DON will monitor compliance.**	**8/24/2010**

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F 157	Continued From page 5 the IM Ativan, she felt the nurses on duty exercised sound nursing judgement when deciding to administer the IM medication. The DON revealed Resident #4's blood pressure was elevated that night and the resident was more agitated than usual. She stated the nursing staff made the decision the IM medication was the most appropriate for the resident under the circumstances. The DON revealed she would not have expected the staff to notify the physician prior to administering the IM medication, because that was the reason the physician had given the standing order for IM use of the Ativan prior to 02/11/10, to be used at the nurse's discretion if the staff felt the resident was more agitated/anxious than usual. A review of the facility policy entitled, "When to Call the Physician Immediately," with no date noted, revealed the physician was to be notified immediately for any of the following reasons. 1. Acute change in mental status or a resident's ability to speak, walk, or use a limb. 2. Acute change in vital signs. 3. No bowel movement in three days not relieved by prn medication. 4. Acute pain or unresolved pain after prn pain medication. 5. Abnormal or critical laboratory values for the resident. 6. The resident or resident's family request the physician be called. 7. Change in the resident's voiding status. 8. Any other significant change in a resident's status.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281	**Services provided meet professional standards NHC does provide and arrange services that meet professional standards of quality of care.**	

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F 281	Continued From page 6 by: Based on interview and record review, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one resident (#2) in the selected sample of 28. On 12/01/09, an order was obtained to notify the physician of blood glucose levels less than 60 milligrams (mg)/ deciliter (d/L) and greater than 500 mg/dL; however, the staff did not notify the physician on 02/17/10, 02/20/10, 03/10/10, 03/14/10, 03/23/10 and 03/31/10, when the resident had blood glucose levels less than 60 mg/dL. Findings include: Resident #2 was admitted to the facility on 11/30/09 with diagnoses to include Anemia, Diabetes Mellitus, History of Falls, and Senile Dementia. A review of the physician's orders, dated 12/01/09, revealed an order was obtained stating the physician was to be contacted if the resident's blood sugar was less than 60 milligrams (mg)/deciliter (dL) or greater than 500 mg/dL. Further, review of the resident's Diabetic Monitoring Log for February 2010 revealed on 02/17/10 at 12:00 PM, the resident's blood glucose was 56 mg/dL, on 02/20/10 at 7:30 AM, the resident's blood glucose was 57 mg/dL, and on 02/25/10 at 7:30 AM, the resident's blood glucose was 53 mg/dL. The record revealed the resident's physician was not notified of the low blood glucose levels. A review of the physician's orders, dated 02/28/10, revealed the order for notifying the physician for blood sugars less than 60 mg/dL or	F 281	**I) 1. Resident #2's (#5099) physician was notified of resident's blood sugar history, specifically low & high readings on 8/12/2010 by the Director of Nursing. New order was received to notify physician for blood sugar readings less than 50 or greater than 450.** **DON reviewed policies with supervisor's #2 and #3 on 8/12/2010.** **2. Center audit conducted with all resident records being reviewed and if not previously notified, the physician was notified of any blood sugar reading <60 or >400 or abnormal signs & symptoms of hyperglycemia or hypoglycemia. New orders were noted as needed. QA completed on 8/12/2010 by DON and Regional Nurse.** **3. Overseen by the Medical Director, Regional Nurse, and Director of Nursing on 8/12/2010, the center's policies for "Insulin Administration" and "Notification of Physician" were reviewed to direct the nursing staff to notify physician when a resident's blood sugar is <60 or >400 and when the patient is exhibiting abnormal signs of hyperglycemia of hypoglycemia or as directed by the resident's current physician order.**	

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F 281	Continued From page 7 greater than 500 mg/dL was carried forward and current. A review of the Diabetic Monitoring Log for March 2010 revealed on 03/10/10 at 7:30 AM, the resident's blood glucose was 48 mg/dL and at 12:00 PM, the resident's blood glucose was 54 mg/dL, on 03/14/10 at 7:30 AM, the resident's blood glucose was 57 mg/dL and at 12:00 PM, the resident's blood glucose was 56 mg/dL, on 03/23/10 at 7:30 AM, the resident's blood glucose was 49 mg/dL and on 03/31/10 at 7:30 AM, the resident's blood glucose was 47 mg/dL. The record revealed the resident's physician was not notified of the low blood glucose levels. An interview, on 08/12/10 at 10:43 AM, with Licensed Practical Nurse (LPN) #2 revealed she was the nurse who completed the Accu Checks on 02/20/10, 02/25/10, and 03/10/10. She stated, "Apparently, I did not call the doctor or chart it. I should have notified the doctor when the blood glucose level was less than 60 mg/dL and also documented it in the resident's record". The LPN revealed she did not follow the physician's orders. An interview, on 08/12/10 at 12:59 PM, with LPN #3 revealed she completed the Accu Checks on 02/17/10, 03/14/10, 03/23/10, and 03/31/10. The LPN stated she did not notify the doctor of the low blood glucose levels obtained. She stated the staff were expected to follow the physician's orders but she did not. An interview, 08/12/10 at 1:45 PM, with the Director of Nursing (DON) revealed the resident had an order to notify the physician with blood glucose levels less than 60. She stated she expected the nurses to follow the order and call the doctor.	F 281	**Overseen by the Director of Nursing on 8/12/2010, Licensed nurses were inserviced on the center's policies for "Insulin Adminstration" & "Notification of Physician". Specific emphasis was given during the inservice on the updated portions of the policies that direct nursing staff to notify the physician when:** **A) A resident's blood sugar is <60 or >400** **B) When the patient is exhibiting abnormal signs of hyperglycemia or hypoglycemia** **C) Or as directed by the resident's current physician order** **4) Overseen by the Director or Nursing, beginning on 8/12/2010, 5 current resident records with orders for blood sugar readings or a history of hyperglycemia or hypoglycemia will be reviewed daily for compliance with the nurse notifying the physician per policy or physician order. These monitors will be continued for 10 days then weekly x6 weeks. Results will be reported to Quality Assurance Committee and the monitors and inservice training will be continued as directed by the QA Committee.**	8/24/2010

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F 281	Continued From page 8 An interview, on 08/12/10 at 2:06 PM, with the Advanced Registered Nurse Practitioner (ARNP) revealed with blood glucose levels less than 60 mg/dL or greater than 400 mg/dL, the staff should have called her. She stated it was the policy of the facility and the staff were expected to follow it. Additionally, the ARNP stated the staff did not call her with the low glucose levels.	F 281		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329	**Drug regimen is free from unnecessary drugs NHC monitors each residents drug regimen for unnecessary drugs.** **II) 1.Resident #4's (#5106) physician was contacted and made aware that PRN Ativan IM was given x1 on 2/11/2010. Discussed resident's agitated condition at the time. Unit Manager met with physician & discussed the IM Ativan order. Order discontinued 8/24/2010.** **2. Residents' with an order for IM Ativan Were identified. Records audited on 8/12/2010 with no new findings.** **3. Inservice of nursing supervisors on facility policies regarding PRN medication use & when to call the physician "immediately" with emphasis on significant change in patient status & adequate indication for use. Initial QA was completed on active IM PRN anti-anxiety medications. Findings were discussed at UR committee meeting 8/24/2010 without any changes or recommendations.** **QA will be continued every 2 weeks and reported to UR committee monthly x3 or as directed by UR committee. DON will monitor compliance.**	

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F 329	Continued From page 9 Based on interviews and record review, it was determined the facility failed to ensure each resident was free from unnecessary drugs for one resident (#4) in the selected sample of 28, related to a standing order for Ativan 0.5 milligrams intramuscular (IM) without adequate indication for its use and subsequent administration of the IM medication without attempting the tablet form of the medication first. Findings include: Resident #4 was admitted to the facility on 01/05/10 with diagnoses to include Left side Hemiparesis, Dysphagia, and Late Effect Cerebral Vascular Accident. A review of Resident #4's quarterly minimum data set (MDS) assessment, with a completion date of 07/14/10, revealed the resident had behaviors which included verbally abusive, physically abusive, socially inappropriate, and resisted care, present from one to three days during the look back period and were easily altered with current interventions. A review of Resident #4's physician orders, dated 07/29/10, revealed an order for Ativan 0.5 mg tablet per G-tube every six hours as needed (prn) for anxiety, with a start date of 01/07/10. The resident's physician orders also revealed an order for Ativan 0.5 mg intramuscular (IM) every six hours prn for anxiety. A review of Resident #4's medication administration record (MAR) , dated February 2010, revealed the resident received the IM medication on 02/11/10 at 4:45 AM for increased anxiety. A review of Resident #4's nurses notes, dated	F 329	**Resident #4's physician was contacted by DON for review of resident's behaviors with medication review.** **IM PRN Ativan was discontinued on 8/24/2010.**	**8/24/2010**

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(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 329	Continued From page 10 02/11/10 at 4:30 AM, revealed the resident was in bed "hollering out I've had a stroke. I can't talk." The entry also noted the resident was continuously moving his/her right arm and leg about on the bed. The nurses notes revealed tender, loving care (TLC) and comfort were provided to the resident. At 4:45 AM the nurses note revealed the resident was given Ativan 0.5 mg IM for increased anxiety. Neither the nurses notes or the MAR contained documentation to indicate the tablet form of the Ativan had been offered or administered prior to the administration of the IM form of Ativan. An interview with Licensed Practical Nurse (LPN) #1, on 08/12/10 at 9:15 AM, who administered the IM medication on 02/11/10, revealed she administered the IM medication, based on her belief that the medication would have quicker absorption with this route of administration and she felt the resident's level of anxiety/agitation was worse than usual. LPN #1 revealed the resident had episodes of yelling and screaming out at times but they seemed louder and more intense on 02/11/10. She revealed she did not give the medication in tablet form through the resident's G-tube. She revealed she did not contact the physician prior to administering the IM medication, because she had the standing order for the IM medication. An interview with Registered Nurse (RN) #1, on 08/12/10 at 9:35 AM, revealed she assessed Resident #4 the night the IM Ativan was administered and the resident was screaming, yelling, and extremely agitated. RN #1 revealed the resident had this type behavior in the past and still exhibited these behaviors on occasion. She revealed the tablet form of the Ativan was not	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185093	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 08/13/2010
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW		STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD., P O BOX 247 GLASGOW, KY 42141	

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F 329	Continued From page 11 discussed but she was aware it was available. RN #1 stated the staff normally attempted the tablet form of the medication prior to the resident escalating to the extreme level of agitation seen that night, but she felt the resident needed the fastest, most effective route the night the IM medication was administered. An interview with the Director of Nursing (DON), on 08/12/10 at 1:20 PM, revealed she did not see an issue with the standing order for IM Ativan for Resident #4. The DON stated on the night Resident #4 received the IM Ativan, she felt the nurses on duty exercised sound nursing judgement when deciding to administer the IM medication. The DON revealed this behavior was typical for Resident #4 but more intense on 02/11/10. She stated she did not expect the staff to attempt the Ativan tablet per the G-tube prior to giving the medication IM, if the nurse felt the IM was indicated and would have been the most effective. An interview with Resident #4's attending physician, on 08/13/10 at 10:40 AM, revealed when Resident #4 first arrived at the facility, the resident was responding to hallucinations and became very agitated, so he ordered both the IM Ativan and the tablet form of the medication, in case the staff felt the resident required medication to aleve the behavior as quickly as possible. The physician revealed the medication had only been used the one time and should have been discontinued, but was one that had just "slipped through the cracks."	F 329		

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

PRINTED: 08/23/2010
FORM APPROVED
OMB NO. 0938-0391

RECEIVED SEP 2010 OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185093		08/11/2010

NAME OF PROVIDER OR SUPPLIER
NHC HEALTHCARE, GLASGOW

STREET ADDRESS, CITY, STATE, ZIP CODE
109 HOMEWOOD BLVD., P O BOX 247
GLASGOW, KY 42141

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on August 11, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 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.	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that exit doors were readily accessible at all times and had the proper signage. The findings include: During the Life Safety Code tour on August 11, 2010 at 1:00 p.m., with the Director of Maintenance, an exit door with a magnetic locking device was noted not to release within fifteen (15) seconds. The door did not have the proper Signagel indicating the door would release in fifteen (15) seconds. The Director of Maintenance stated the magnetic locks were not delayed egress locks and would only open with the adjacent key pad or the activation of the fire	K 038	NHC of Glasgow does allow exit access at all times according to section 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. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies or portions of health care occupancies where clinical needs of the patients require specialized security measures for their safety provided staff can readily unlock such doors at all times. (See 19.1.1.1.5 & 19.2.2.2.5) The 8 exit doors have been reprogrammed and staff educated. Inservice completed on 8-30-2010. Signage has been posted adjacent to the release device for each exit door stating "In Case of Emergency Press 5*." The signage is 1" high and 1/8" wide on a contrasting background. The code will be a part of all new partner orientation. QA will be continued weekly x4 and reported to UR Committee monthly x3. The maintenance supervisor will monitor QA.	9/09/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eugene C. Stephens
TITLE: adm
(X6) DATE: 9-9-10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185093	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/11/2010

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K 038	Continued From page 1 alarm system. The Director of Maintenance was not aware the door should open within fifteen (15) seconds and have the proper Signagel. Approximately nine (9) other exit doors were noted not to release or have the proper Signagel during the survey. Reference: NFPA 101 2000 edition 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority	K 038		

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K 038	Continued From page 2 having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038		