

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

PRINTED: 09/29/2011
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2011
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW			STREET ADDRESS, CITY, STATE, ZIP CODE 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 survey and an abbreviated survey (KY #16963) was conducted on 09/13/11 through 09/15/11 and a Life Safety Code survey was conducted on 09/14/11 to determine the facility's compliance with Federal requirements. The facility failed to meet requirements for recertification with the highest S/S of an "E." KY #16963 was unsubstantiated with no deficiencies cited.	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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 280	F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP NHC of Glasgow does encourage resident to participate their planning of care and treatment as well as revision in plan of care. Comprehensive assessment is completed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the physician, a registered nurse with responsibility for the resident, & other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family, the participation of the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	

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

TITLE

(X6) DATE

Emogene C. Stephens

adm

11-10-11

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 280	<p>Continued From page 1</p> <p>interview, it was determined the facility failed to ensure the plan of care was revised for one resident (#7), in the selected sample of 28. Resident #7 was assessed for no siderail use while in the bed, but the Certified Nurse Aide (CNA) care plan reflected siderails were to be used.</p> <p>The findings include:</p> <p>A record review revealed Resident #7 was admitted to the facility on 08/10/10 with diagnoses to include a History of Falls, Dementia, Anxiety, Weakness and Alzheimer's Disease. A review of the Fall Risk Assessment, dated 08/09/11, revealed the resident was identified to be at high risk for falls. A review of the annual Minimum Data Set (MDS), dated 08/11/11, revealed the facility identified the resident to be severely cognitively impaired and required limited assistance with bed mobility and transfers.</p> <p>A review of the Physical Restraint assessment, dated 08/25/11, revealed the siderails were to be lowered at all times, as the resident did not need the siderails to enhance bed mobility. A review of the CNA care plan titled "Patient Information," undated, revealed half siderails were to be raised on both sides of the bed.</p> <p>Observations, on 09/13/11 at 3:40 PM, on 09/14/11 at 8:35 AM, 10:15 AM, and 12:40 PM, and on 09/15/11 at 9:30 AM, revealed Resident #7 was in the bed with bilateral siderails raised.</p> <p>An interview with Unit Supervisor #1, on 09/15/11 at 2:15 PM, revealed she completed the assessment for the resident's siderails, on</p>	F 280	<p>Resident #7 CNA plan of care was updated by Unit Manager 10-03-2011. Side rail assessment reviewed & accurate. In-house resident CNA plan of care reviewed by licensed nurses and updated 10/05/11. Initial QA completed 10/05/2011 by Unit Manager. No other resident identified or affected.</p> <p>Inservice for nursing partners on care plan and side rail use on those assessed to need side rails, by licensed nurse 10/06/11. Overseen by DON.</p> <p>QA monthly x 3 of 10 resident per station by unit manager or as directed by UR committee on comparing CNA care plan information to assessment accuracy. DON to monitor compliance.</p>

10/7/2011

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F 280	Continued From page 2 08/25/11, and the resident should not have siderails raised while in the bed. She revealed the CNA care plan should be updated to reflect the assessment, and "that is my fault." An interview with the Director of Nursing (DON), on 09/15/11 at 3:15 PM, revealed if a siderail assessment was completed for a resident, she expected the care plan to reflect the assessment.	F 280			
F 282 SS-D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure care was provided in accordance with the written plan of care for two residents (#1 and #14), in the selected sample of 28. Resident #1's care plan revealed no siderail use while in the bed. Observations, on 09/14/11 and 09/15/11, revealed a siderail was in use for this resident. Resident #14's care plan revealed alarms would be placed in a "mesh bag," as a fall intervention due to a history of disassembling alarms. Observations, on 09/13/11 through 09/15/11 revealed the resident's alarms were not in a "mesh bag." The findings include: 1. A record review revealed Resident #1 was	F 282	F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN NHC provides &/or arranges services of Qualified persons in accordance with each resident's written plan of care. Resident #1 Care plan was revised by Unit Manager on 10-03-2011. Resident #14 Care plan revised by Unit Manager and discontinued use of mesh bag after eval by Falls Nurse and Unit Manager. No other resident identified/affected after in-house audit by Falls Nurse 10/03/2011. Inservice of nursing partners on CNA care plan policy and procedures by Licensed Nurses with oversight by DON 10/06/11. QA monthly x 3 of 10 residents per station to ensure accuracy of CNA care plan information, or directed by UR committee. DON to monitor compliance.	10/7/2011	

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F 282	<p>Continued From page 3</p> <p>admitted to the facility on 02/11/10 with diagnoses to include Dementia, Anxiety, Agitation and Combativeness.</p> <p>A review of the Physical Restraint assessment, dated 02/25/11, revealed the resident did not require any siderails for positioning or bed mobility. A review of the previous assessments, dated 04/04/11 and 07/04/11, revealed there were no changes and siderails were not in use.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 07/04/11, revealed the facility identified the resident to be severely cognitively impaired and required extensive assistance with bed mobility and transfers. A review of the Fall Risk Assessment, dated 07/04/11, revealed the resident was identified to be at high risk for falls.</p> <p>A review of the Certified Nurse Aide's (CNA) care plan titled "Patient Information," undated, revealed no siderails were in use for Resident #1.</p> <p>Observations, on 09/14/11 at 8:40 AM and 10:15 AM, and on 09/15/11 at 9:25 AM, revealed Resident #1 was in the bed with one siderail raised on his/her left side. The bed was against the wall on the right side.</p> <p>Interviews with CNA #2 and CNA #4, on 09/15/11 at 10:50 AM and 11:10 AM, respectively, revealed the CNA care plan revealed if a resident should have siderails raised or not, but the care plans were not reviewed everyday.</p> <p>An interview with CNA #5, on 09/15/11 at 11:20 AM, revealed she worked dayshift and was responsible for the resident's care on 09/14/11</p>	F 282		

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F 282	<p>Continued From page 4</p> <p>and on 09/15/11. She stated the resident was care planned to have the left siderail raised. CNA #5 revealed she did not review the resident's care plan on 09/14/11 or on 09/15/11, but it should be reviewed on a daily basis.</p> <p>An interview with the Director of Nursing (DON), on 09/15/11 at 3:15 PM, revealed she expected the CNAs to review and follow the care plans daily.</p> <p>2. A record review revealed Resident #14 was admitted to the facility on 06/02/10 with diagnoses to include Parkinson's Disease, Aphasia and Depression with Anxiety.</p> <p>A review of Resident #14's Comprehensive Care Plan, dated 11/10/10, revealed "at risk for falls related to dizziness and confusion, attempts to self-transfer and ambulate at times, and unaware of his/her safety needs."</p> <p>A review of the facility's Post Fall Nursing Assessment, dated 01/03/11, revealed Resident #14 was found sitting up on his/her buttocks off the side of the bed. The mat alarm was turned off. Because of a known history of disassembling alarms, an intervention was added to place both the mat alarm and the clip alarm controls in a mesh bag.</p> <p>A review of Resident #14's Fall Risk Assessment, dated 07/22/11, revealed the facility identified Resident #14 to be at high risk for falls. A review of the quarterly MDS, dated 07/26/11, revealed the facility identified Resident #14 to be moderately cognitively impaired and required extensive assistance with activities of daily living</p>	F 282		

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F 282	<p>Continued From page 5 (ADLs).</p> <p>Observations, on 09/13/11 at 3:45 PM, on 09/14/11 at 8:40 AM and 10:25 AM, and on 09/15/11 at 9:35 AM, 11:29 AM and 2:58 PM, revealed both the mat alarm and the clip alarm were in place; however, they were not stored in the mesh bags.</p> <p>Interviews with Certified Nurse Aide (CNA) #6 and CNA #7, on 09/15/11 at 3:58 PM and 4:05 PM, respectively, revealed they reviewed the CNA care plans once a week, but were unaware Resident #14 required his/her alarms to be stored in the mesh bags.</p> <p>An interview with CNA #9, on 09/15/11 at 4:40 PM, revealed she reviewed the CNA care plans frequently for changes. Additionally, she stated Resident #14 required his/her alarms to be placed in mesh bags so he/she would not disassemble them.</p> <p>Interviews with Registered Nurse (RN) #3 and Licensed Practical Nurse (LPN) #1, on 09/15/11 at 4:12 PM and 4:17 PM, respectively, revealed they expected the CNAs to check their CNA care plans routinely to ensure changes were not missed. Additionally, they stated Resident #14 required his/her alarms to be stored in the mesh bags, because he/she was known to disassemble the alarms.</p> <p>An interview with the Director of Nursing (DON), on 09/15/11 at 4:48 PM, revealed she expected the CNAs to review the CNA care plans on a daily basis. CNAs and nurses were responsible for checking the placement of the alarms.</p>	F 282		

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F 282	Continued From page 6 Additionally, she stated Resident #14 required storage of his/her alarms in mesh bags due to a history of disassembling the alarms. Mesh bags were initiated for residents with impaired cognition and without the bags, a resident could turn the alarm off.	F 282		
F 323 SS-E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure the resident's environment remained free of accident hazards as is possible for seven (7) residents (#1, #3, #7, #9, #14, #15, and #16), in the selected sample of 28. Residents #1 and #7, were assessed for the use of side rails; however, it was determined the side rails would not be utilized. The care plans were not followed as evidenced by observations of the side rails being raised on both residents' beds, during the survey process. Residents #3, #9, #15, and #16 were not assessed prior to the use of air mattresses to determine risk factors and/or potential accident hazards. Additionally, Resident #14's care plan revealed alarms would be placed in a "mesh bag," as a fall intervention due to a history of	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES NHC ensures that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. 1. Resident #14 Care plan revised by Unit Manager. Protocol for checking usage of body alarms revised 10/11 by Medical Director, Administrator and DON. No other resident identified/affected by in-house audit by Falls Nurse on 10/03/11. Inservice nursing partner's on revised protocol for checking usage of body alarms & nurse aide care plan policy by Licensed Nurses and oversight by DON 10/06/11. QA monthly x 3 for 10 residents on each unit for accuracy of CNA care plan & compliance of alarm usage/storage as directed by UR Committee. DON to monitor compliance.	

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F 323	<p>Continued From page 7</p> <p>disassembling alarms. Observations, on 09/13/11 through 09/15/11 revealed the resident's alarms were not in a "mesh bag."</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Assistive Devices," undated, revealed "To provide a consistent process to routinely assess residents based on the need, appropriateness and safe use of assistive devices."</p> <p>1. A record review revealed Resident #14 was admitted to the facility on 06/02/10 with diagnoses to include Parkinson's Disease, Aphasia and Depression with Anxiety.</p> <p>A review of Resident #14's Comprehensive Care Plan, dated 11/10/10, revealed "at risk for falls related to dizziness and confusion, attempts to self-transfer and ambulate at times, and unaware of his/her safety needs."</p> <p>A review of Resident #14's Fall Risk Assessment, dated 07/22/11, revealed the facility identified Resident #14 to be at high risk for falls. A review of the quarterly Minimum Data Set (MDS), dated 07/26/11, revealed the facility identified Resident #14 to be moderately cognitively impaired and required extensive assistance with activities of daily living (ADLs).</p> <p>A review of the Post Fall Nursing Assessment, dated 01/03/11, revealed Resident #14 was found sitting up on his/her buttocks off the side of the bed. The mat alarm was turned off. Because of a known history of disassembling alarms, an intervention was added to place both the mat</p>	F 323	<p>2. - 3. Resident #1 & #7 Care plan's revised by Unit Manager. I on 1 counseling to CNA's assigned to residents on 09/13/2011 - 09/15/2011 on safety of residents & following plan of care by Unit Manager. No other resident identified/affected.</p> <p>Inservice nursing partners on Nurse aide care plan policy and procedure by Licensed Nurses and oversight by DON on 10/06/11.</p> <p>QA - Questionnaire of nursing partner's as to policy & procedure of CNA care plan. 5 partners weekly per station (involving all shifts) x 1 month then monthly x 3 or as directed by UR committee. DON to monitor compliance.</p> <p>4. - 7. Resident's #16, #3, #9, & #15 were assessed by Unit Managers using the air mattress assessment. All resident's using an air mattress were assessed as of 10/05/2011.</p> <p>Assessment will be done on admission, quarterly, annually, & on change of status if air mattress is in use.</p> <p>Inservice for nursing partners of use, frequency, reason/indication, noting risks & benefits by Unit Managers and oversight by DON 10/06/11.</p> <p>QA monthly for air mattress assessment of 5 residents per station x 2 months or as directed by UR committee. DON to monitor compliance.</p>	10/7/2011

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F 323	<p>Continued From page 8</p> <p>alarm and the clip alarm controls in a mesh bag.</p> <p>Observations, on 09/13/11 at 3:45 PM, on 09/14/11 at 8:40 AM and 10:25 AM, and on 09/15/11 at 9:35 AM, 11:29 AM and 2:58 PM, revealed both the mat alarm and the clip alarm were in place; however, they were not stored in the mesh bags.</p> <p>Interviews with Certified Nurse Aide (CNA) #6 and CNA #7, on 09/15/11 at 3:58 PM and 4:05 PM, respectively, revealed they reviewed the CNA care plans once a week, but were unaware Resident #14 required his/her alarms to be stored in the mesh bags.</p> <p>An interview with CNA #9, on 09/15/11 at 4:40 PM, revealed she reviewed the CNA care plans frequently for changes. Additionally, she stated Resident #14 required his/her alarms to be placed in mesh bags so he/she would not disassemble them.</p> <p>Interviews with Registered Nurse (RN) #3 and Licensed Practical Nurse (LPN) #1, on 09/15/11 at 4:12 PM and 4:17 PM, respectively, revealed they expected the CNAs to check their CNA care plans routinely to ensure changes were not missed. Additionally, they stated Resident #14 required his/her alarms to be stored in the mesh bags, because he/she was known to disassemble the alarms.</p> <p>An interview with the Director of Nursing (DON), on 09/15/11 at 4:48 PM, revealed she expected the CNAs to review the CNA care plans on a daily basis. CNAs and nurses were responsible for checking the placement of the alarms.</p>	F 323		

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F 323	<p>Continued From page 9</p> <p>Additionally, she stated Resident #14 required storage of his/her alarms in mesh bags due to a history of disassembling the alarms. Mesh bags were initiated for residents with impaired cognition and without the bags, a resident could turn the alarm off.</p> <p>2. A record review revealed Resident #1 was admitted to the facility on 02/11/10 with diagnoses to include Dementia, Anxiety, Agitation, and Combativeness.</p> <p>A review of the quarterly MDS, dated 07/04/11, revealed the facility identified the resident to be severely cognitively impaired and required extensive assistance with bed mobility and transfers. A review of the Fall Risk Assessment, dated 07/04/11, revealed the resident was identified at high risk for falls.</p> <p>Observations, on 09/14/11 at 8:40 AM, 10:15 AM, and on 09/15/11 at 9:25 AM, revealed Resident #1 was in the bed with one side rail up on the left side. The bed was against the wall on the right side.</p> <p>A review of the Physical Restraints assessment, dated 02/25/11, revealed the resident did not require side rails for positioning or bed mobility. A review of assessments, dated 04/04/11 and 07/04/11, revealed there were no changes and side rails were not in use.</p> <p>A review of the CNA care plan titled "Patient Information," undated, revealed no side rails were in use for Resident #1.</p> <p>Interviews with CNA #2 and CNA #4, on 09/15/11</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW		STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 10</p> <p>at 10:50 AM and 11:10 AM, respectively, revealed the CNA care plan indicated if a resident had side rails, but the care plans were not reviewed everyday.</p> <p>An interview with CNA #5, on 09/15/11 at 11:20 AM, revealed she worked dayshift and was responsible for the resident's care on 09/14/11 and 09/15/11. She revealed the resident was care planned to have the left side rail raised. CNA #5 revealed she had not checked the resident's care plan on 09/14/11 or 09/15/11, but it should be checked daily.</p> <p>3. A record review revealed Resident #7 was admitted to the facility on 08/10/10 with diagnoses to include a History of Falls, Dementia, Anxiety, Weakness and Alzheimer's Disease.</p> <p>A review of the annual MDS, dated 08/11/11, revealed the facility identified the resident to be severely cognitively impaired and required limited assistance with bed mobility and transfers. A review of the Fall Risk Assessment, dated 08/09/11, revealed the resident was identified at high risk for falls.</p> <p>Observations, on 09/13/11 at 3:40 PM, on 09/14/11 at 8:35 AM, 10:15 AM, and 12:40 PM, and on 09/15/11 at 9:30 AM, revealed Resident #7 was lying in the bed with side rails raised on both sides.</p> <p>A review of the Physical Restraint assessment, dated 08/25/11, revealed the side rails were to be left down at all times as the resident did not need them to enhance bed mobility. A review of the CNA care plan titled "Patient Information,"</p>	F 323		

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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 323	<p>Continued From page 11</p> <p>undated, revealed half side rails were to be raised bilaterally.</p> <p>An interview with Unit Supervisor #1, on 09/15/11 at 2:15 PM, revealed she completed the assessment for the resident, on 08/25/11, and the resident should not have side rails raised while in the bed. She revealed the CNA care plan should be updated to reflect the assessment, and "that is my fault."</p> <p>4. A record review revealed Resident #16 was admitted to the facility on 07/29/11 with diagnoses to include a History of a Fall with a Hip Fracture, Arthritis and Anxiety State.</p> <p>A review of the admission MDS, dated 08/11/11, revealed the resident had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident was moderately cognitively impaired cognition. He/she required extensive assistance of two staff members for bed mobility, toileting and transfers and limited assistance of one staff to ambulate in the room and in the hallway.</p> <p>A review of the care plan for "skin integrity," dated 07/29/11, revealed the resident required a pressure reducing air flotation mattress on his/her bed. A review of the assessment for physical restraints, dated 07/29/11, and the assessment for the safe use of the lift chair, dated 08/03/11, revealed no assessment for the safe use of the pressure reducing air flotation mattress.</p> <p>An observation, on 09/13/11 at 10:40 AM, revealed the resident was resting quietly in the bed and talking with a sitter at the bedside. A</p>	F 323	

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F 323	<p>Continued From page 12</p> <p>pressure reducing air flotation device mattress was set for a comfort setting of three (3), with the setting of one (1) being the softest setting and ten (10) being the firmest setting. The device was set for alternating pressure and two half side rails were raised.</p> <p>5. A record review revealed Resident #3 was admitted to the facility with diagnoses to include Transient Cerebral Ischemia, Acute and Subacute Necrosis of the Liver, Acute Myocardial Infarction.</p> <p>A review of the admission MDS, dated 08/09/11, revealed Resident #3 was cognitively intact and required extensive assistance of two staff for bed mobility and transfers. The resident was assessed to be at risk for developing a pressure ulcer. During re-admission to the facility on 08/29/11, the resident was identified with five pressure ulcers with treatments in place.</p> <p>Observations, on 09/13/11 at 11:05 AM, and on 09/14/11 at 8:30 AM, 11:00 AM, and 1:05 PM, revealed the resident was resting on his/her right side. The resident was resting on a speciality mattress set on a comfort level of "5."</p> <p>Further record review revealed there was no assessment for the safe use of an air mattress to include the risk and benefits.</p> <p>6. A record review revealed Resident #9 was admitted to the facility with diagnoses to include Back Pain, Diabetes Mellitus, Decubitus to the Coccyx and Chronic Obstructive Pulmonary Disease.</p>	F 323		

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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 323 Continued From page 13 F 323

A review of the quarterly MDS, dated 06/22/11, revealed Resident #9 required extensive assistance of two staff for bed mobility. The resident was identified with a Stage III wound to his/her coccyx with treatments in place.

Observations, on 09/14/11 at 8:23 AM, 10:00 AM, 11:00 AM, 1:20 PM and 3:30 PM, revealed he/she was lying in his/her bed with quarter side rails raised and resting on a speciality mattress.

A review of Resident #9's record revealed there was no assessment for the safe use of an air mattress to include the risk and benefits.

7. A record review revealed Resident #15 was admitted to the facility on 09/10/09 with diagnoses to include Atherosclerosis, Arthritis, Tremors and Anxiety.

A review of the annual MDS, dated 08/02/11, revealed the facility identified the resident to be cognitively intact and required extensive assistance with bed mobility and total assistance with transfers.

Observations, on 09/13/11 at 11:20 AM, 3:30 PM, on 09/14/11 at 8:40 AM, 10:15 AM, 10:55 AM, and on 09/15/11 at 9:25 AM, revealed Resident #15 was lying in the bed on an air mattress set to a firm (5) comfort level.

There was no evidence of an assessment for the safe use of the air mattress.

An interview with the Unit Manager (Unit 2), on 09/15/11 at 11:40 AM, revealed she completed an assessment for side rails, but she did not

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F 323	<p>Continued From page 14</p> <p>complete an assessment for the air mattresses. She stated the side rails were assessed upon admission and every three months. She had not completed an assessment for the air mattress. The Unit Manager stated the air mattress had four chambers with air and was covered with a foam padding. She verbalized the mattress was chosen for the residents because the chambers would not deflate easily and the bed had a reduced risk of propelling a resident from the bed. She stated the facility chose the particular brand of air mattress based on that fact. She revealed she was not aware of any incidents in the facility of residents being thrown from the bed related to the air chambers deflating. She revealed she understood the necessity for assessing for the safe use of the mattress, but never thought to assess the air mattress.</p> <p>An interview with the Unit Manager (Unit 3), on 09/15/11 at 2:18 PM, revealed the pressure reducing air flotation devices used at the facility had a "subtle movement," which was almost undetected when lying on the mattresses. The mattresses were composed of four air-filled chambers and covered with a two-inch foam cover. However, there was no assessment completed to determine if the resident was appropriate for the safe use of the mattress.</p> <p>An interview with the Falls Coordinator, on 09/15/11 at 10:26 AM, revealed it was nursing judgment to determine whether a resident benefited from an air mattress and a nurse could place the resident on an air mattress at any time. She did not consider an air mattress to have a higher risk of falls than a regular mattress, because there was not a lot of air movement to</p>	F 323		

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F 323	Continued From page 15 have the potential to move the resident out of the bed. An interview with the Director of Nursing (DON), on 09/15/11 at 3:15 PM, revealed she tried to ensure staff had consistent assignments so they would be familiar with the residents. She expected the CNAs to check and follow the care plans daily. She revealed if an assessment was completed on a resident, she expected the care plan to reflect the assessment.	F 323		
F 371 SS-E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure food was stored, prepared and distributed under sanitary conditions. Observations of the facility's kitchen revealed the ice machine with a build up of a dull black substance which covered a large portion of the ice machine lid. Additionally, observation of the salad bar revealed spaghetti was being served at a temperature of 106 degrees Fahrenheit (F).	F 371	F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The ice machine was thoroughly cleaned by dietician and dietary aide with disinfectant spray and scouring pad on 09/13/2011. An inservice covering the topic of equipment cleaning was held on 09-21-2011. The inservice was conducted by the dietician. Monitoring of ice machine cleanliness was completed and a quality assurance study will be conducted weekly for three months and thereafter as directed by QA committee to be overseen by the dietician. All hot foods will be kept at 135° fahrenheit or higher to ensure food safety for all residents. An inservice covering procedures to follow to ensure that food is at proper temperature was held for dietary employees on 09/21/11 by Registered Dietician.	

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F 371	<p>Continued From page 16</p> <p>The findings include:</p> <p>An observation, on 09/13/11 at 11:15 AM, revealed the lid on the ice machine had a large area of thick, dull black and grey colored substance, which covered a large portion of the lid. Additionally, a build-up of dust was observed on the side vents of the ice machine.</p> <p>An observation of the meal service, on 09/13/11 at 12:15 PM, revealed baked spaghetti was being served from a large metal pan which was not in a warming device. A temperature of the baked spaghetti was obtained by Dietary Aide #1, and was revealed to be 106 degrees F.</p> <p>An interview with Dietary Aide #1, on 09/13/11 at 12:15 PM, revealed she served the baked spaghetti from the baking pan during the meal service, from 10:45 AM through 12:15 PM.</p> <p>An interview with the Dietary Manager, on 09/13/11 at 11:15 AM, revealed the ice machine was cleaned the previous day and she signed off on it. She stated she was not aware the black and grey substance on the ice machine lid could be cleaned, and the ice machine was routinely cleaned two times a week. The Dietary Manager revealed the baked spaghetti, being served from the salad bar, should be in a container which would hold the temperature at a safe and appropriate temperature.</p> <p>An interview with the Administrator, on 09/15/11 at 3:00 PM, revealed a warming device was purchased especially for the salad bar specialty items, and had no explanation as to why the Dietary Aide did not utilize the warming device for</p>	F 371	<p>Monitoring of all food temperatures was done and a quality assurance study will be conducted weekly for three months and thereafter as directed by QA committee to be overseen by the dietician.</p>	09/23/2011

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F 371 F 502 SS=0	<p>Continued From page 17 the spaghetti.</p> <p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's policy/procedure and interview, it was determined the facility failed to ensure timeliness of laboratory services for one resident (#1), in the selected sample of 28. A urine culture & sensitivity (C&S) was ordered for Resident #1, on 03/11/11. Results of the C&S, which revealed a Urinary Tract Infection (UTI), were not received until 03/21/11.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure "Lab/X-ray Orders," undated, revealed cultured laboratory results were expected within 72 hours of being sent to the lab.</p> <p>A record review revealed Resident #1 was admitted to the facility on 02/11/10 with diagnoses to include Dementia, Hypertension and Diverticulosis. A review of the quarterly Minimum Data Set (MDS), dated 07/04/11, revealed the facility identified the resident to be severely cognitively impaired, frequently incontinent of bowel and bladder, and required total assistance with his/her hygiene needs.</p>	F 371 F 502	<p>NHC does provide &/or obtain laboratory Services to meet the needs of its residents, with quality and timeliness.</p> <p>Resident #1 Situation was resolved in April 2011 as lab services provider now Does Cultures in-house.</p> <p>Inservice of nursing partners on revised lab policy & procedure with emphasis on notifying physician and documenting pending labs conducted by Licensed Nurses and overseen by DON completed on 10/06/2011.</p> <p>QA weekly x 4 of 5 residents per station, x 2 months or as directed by UR committee. DON to monitor compliance.</p>	10/7/2011

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F 502	<p>Continued From page 18</p> <p>A review of the physician's orders, dated 03/11/11, revealed an order for a urine C&S. A review of the culture results, dated 03/21/11, revealed two organisms (Proteus Mirabilis and Escherichia Coli) were identified. Further review of the record revealed a physician's order, dated 03/22/11, for an antibiotic to treat the resident's UTI.</p> <p>An interview with Unit Supervisor #1, on 09/15/11 at 2:15 PM, revealed it usually took "a couple of days" to get a C&S back from the lab. She revealed the facility called the lab daily until results of the C&S were received, but she was unable to provide documentation. She could not provide an explanation in regard to Resident #1's lab results; however, she revealed it did not typically take ten (10) days to receive results.</p> <p>An interview with the Microbiology Technician (from the lab), on 09/15/11 at 2:50 PM, revealed the lab sent cultures to an outside facility, in March 2011, as they were not able to conduct these tests in their lab. He revealed the lab was now able to do the cultures "in-house," and the results were usually received within 48 hours.</p> <p>An interview with the Primary Physician, on 09/15/11 at 3:00 PM, revealed he "preferred" results of a C&S within 72 hours.</p>	F 502			

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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</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type 111(000)</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detection.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II diesel generator.</p> <p>A life safety code survey was initiated and concluded on September 14, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000		

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

TITLE

(X6) DATE

Emogene C. Stephens

adm

10-7-11

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.