

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

PRINTED: 12/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/05/2013
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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW	STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/24/13 as alleged.</p>	{F 000}		
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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.

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F 000 F 281 SS=D	<p>INITIAL COMMENTS</p> <p>A Recertification survey was conducted on 10/09/13 through 10/11/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "F".</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy and procedure review it was determined the facility failed to ensure services provided by the facility meet professional standards of quality for one (1) of twenty-nine (29) sampled residents (Resident #6). Resident #6 was to have a medication patch applied every morning after removing the patch from the previous day. Observation on 10/07/13 revealed Resident #6 had a medication patch on his/her left posterior and anterior shoulder at the same time.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Preparation and General Guidelines", last revised 12/09, revealed medications should be administered in accordance with written orders of the attending physician.</p> <p>Record review revealed the facility admitted Resident #6 on 10/04/13 with diagnoses which</p>	F 000 F 281	<p>The plan of correction is submitted as required under the State and Federal Law. The facilities' submission of the Plan of Corrections does not constitute as admission on the part of the facility that the findings constitute deficiency, or the scope and severity determination is correct.</p> <p>NHC- Glasgow does provide services which meet professional standards.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Admin. (X6) DATE 11/4/13

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

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F 281	<p>Continued From page 1</p> <p>included Dementia, Acute Kidney Failure and Schizophrenia.</p> <p>Review of an admission Minimum Data Set (MDS) assessment, dated 10/10/12, revealed the facility assessed Resident #6 as cognitively impaired and dependent on staff for assistance with all activities of daily living.</p> <p>Observation on 10/09/13 at 9:40 AM revealed Resident #6 was resting in bed dressed in a gown. The resident's left shoulder was visible as the neck opening of the gown was loose. An Exelon (treatment of dementia) 9.5 milligram (mg.) patch was on the back of the resident's left shoulder and was dated 10/08/13. An Exelon patch 9.5 mg was also observed on the front side of the left shoulder with a date of 10/09/13.</p> <p>Review of a physician's order, dated 10/04/13, revealed Exelon Patch 9.5 mg/24 hours. Apply new patch daily.</p> <p>Review of Exelon Patch 9.5 mg/24 hours packaging revealed "WEAR ONLY ONE PATCH AT A TIME" Replace with a new patch every 24 hours. Review of PDR Nurse's Drug Handbook, page 473, revealed "Do not apply two patches at once".</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 10/09/13 at 9:40 AM, revealed Certified Medication Aide (CMA) #3 had placed the patch on the resident on 10/09/13. She stated two Exelon Patches should never be in place at the same time.</p> <p>Interview with CMA #3, on 10/09/13 at 10:25 PM revealed she had placed the Exelon 9.5 mg patch</p>	F 281	<p>Previous medication patch removed by nurse post awareness. Physician noted of situation with no known harm.</p> <p>One to one education done with identified parnter on policy and standard of practice.</p> <p>A list of residents who have orders for transdermal obtained.</p> <p>All residents monitored and no other patient identified to have greater than one patch.</p> <p>An in-service of nurses and CMA's on Transdermal drug delivery system protocol was conducted by Unit Managers.</p> <p>DON or designee will monitor all residents with transdermal drug delivery system weekly for 6 weeks, then monthly for 3 months, then as determined by Quality Improvement Committee, ADM, DON, Medical Director, Social Services, Health Information , and Quality Improvement Coordinator.</p>	11/15/13	

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F 281	Continued From page 2 on Resident #6 during the morning medication pass sometime around 9:00 AM. CMA #3 stated she "just forgot to remove the patch from the previous day". She additionally stated she thought having two of the patches in place could cause dizziness and light headedness. Interview with the Director of Nursing (DON), on 10/09/13 at 11:00 AM, revealed the procedure should be to always remove the patch from the day before before applying a new one. She stated there could be adverse symptoms from having two patches in place at the same time and there should be monitoring in place to look for any symptoms. Interview with the facility Pharmacist, on 10/09/13 at 11:25 AM, revealed Exelon patches were used to treat Dementia in residents. He also stated only one patch at a time should be in place. The Pharmacist stated adverse symptoms of nausea, head ache, dizziness, blurred vision, affects to facial nerves and diarrhea could be experienced by anyone utilizing the Exelon patches. He also stated those symptoms could be more severe if two patches were in place simultaneously.	F 281			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was	F 332			

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F 332	<p>Continued From page 3</p> <p>determined the facility failed to ensure it was free of medication error rates of five (5) percent (%) or greater. Observations of medication passes revealed thirty-eight (38) opportunities with two (2) errors which resulted in a 5% error rate, involving two (2) unsampled residents (Resident A and B).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the "Medications Not to be Crushed" list, last revised 01/11, revealed Guaifenesin (antihistamine) Extended Release (ER) tablets were noted on the list. <p>Observation of a medication pass for Resident (A), on 10/10/13 at 9:25 AM, revealed Licensed Practical Nurse (LPN) #1 administered Mucinex (Guaifenesin) ER, (1) crushed 600 mg tablet to the resident.</p> <p>Record review revealed Resident (A) was admitted to the facility on 08/18/10. Review of the Medication Administration Record (MAR) for Resident (A), dated 10/01-31/13, revealed an order for Guaifenesin Extended Release (ER) 600 milligrams (mg) by mouth every twelve hours.</p> <p>Interview with LPN #1, on 10/10/13 at 11:10 AM, revealed she did not notice the Mucinex order specified it was an extended release tablet. She verified the package for the Mucinex, sent from the pharmacy, indicated it was an extended release tablet. She revealed there was a "do not crush" list of medications available for use while passing medications.</p> <p>Interview with the Director of Nursing (DON), on 10/11/13 at 11:40 AM, revealed she expected</p>	F 332	<p>Nurse # 1 was re-educated on protocol of administering non-crushable meds by Unit Manager. Nurse#2 was educated on medication administration following Physician orders by DON. Physician informed on 10-10-13 with no changes.</p> <p>All other residents with orders for crushed meds or to be taken with food were reviewed. No other residents were affected.</p> <p>An In-service of RN/LPN/CMA's on administration of crushed meds and/ or must be given with food conducted by DON or Designee.</p> <p>A Quality Improvement for compliance of following Physicians orders will be conducted by DON or Designee Med pass weekly for six weeks and then monthly for three weeks, then as determined by Quality Improvement Committee, ADM, DON, Medical Director, Social Services, Health Information, and Quality Improvement Coordinator.</p>	11/15/13

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F 332	Continued From page 4 staff to know the medications administered to residents. She revealed there was a "do not crush" list available for staff, if needed. 2. Observation of a medication pass, on 10/10/13 at 9:00 AM, for Resident #B revealed LPN #2 administered Amitiza (for treating Irritable Bowel Syndrome with Constipation) 8 micrograms (mcg) with eleven (11) other medications. The medications were administered with a glass of water. Record review revealed the facility admitted Resident #B on 09/18/12. Review of a physician's order, dated October 2013, revealed Amitiza (for treating Irritable Bowel Syndrome with Constipation) 8 mcg capsule one (1) by mouth twice daily with meals. Interview with LPN #2, on 10/10/13 after the medication pass observation, revealed she did not provide the medication with a meal and could have offered a snack. Interview with the DON, on 10/10/13 at 11:05 AM, revealed she expected medications to be administered according to the the Physician's Order and the medication should have been given with a meal.	F 332			
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.	F 360	NHC-Glasgow does provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs.		

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F 360	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide each resident with a nourishing, well-balanced diet that met the daily nutritional needs of each resident for one (1) of twenty-nine (29) sampled residents (Resident #5).</p> <p>The findings include:</p> <p>Review of the Weight Monitoring policy/procedure, revised 08/01/07, revealed weights would be monitored to maintain acceptable nutritional parameters. Interventions would be developed and documented by the interdisciplinary team.</p> <p>Review of the Diet Liberalization policy, revised May 2013, revealed residents would be served a liberalized meal plan based on a holistic assessment of their individual nutritional needs.</p> <p>Record review revealed the facility admitted Resident #5 on 11/02/10 with a diagnoses which included Diabetes and Dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/03/13, revealed the facility assessed the resident as moderately cognitively impaired.</p> <p>Observation, on 10/10/13 at 12:10 PM, revealed the lunch tray card for Resident #5 indicated the following preferences:</p> <ol style="list-style-type: none"> 1. Milk, 2% (8 oz) 2. Lemonade (8 oz) 3. Milkshake, sugar free 4. ice cream, sugar free 	F 360	<p>All foods/ supplements used for weight loss prevention will be identified with a # symbol beside it of the diet tray card.</p> <p>An in-service was conducted by dietitation to educate dietary partner on the identification of weight loss interventions on dietary tray card.</p> <p>Nursing dept. will be in-serviced by Director of Nursing or designee on symbol # which will be on tray card to designate for purpose of potential weight loss.</p> <p>The Dietary Manager will monitor 15% of the diet card and resident tray for accuracy by visual observation weekly for six weeks, then monthly for 3 months,</p> <p>then as determined by Quality Improvement Committee, ADM, DON, Medical Director, Social Services, Health Information , and Quality Improvement Coordinator.</p>	11/24/13

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F 360	<p>Continued From page 6</p> <p>The observation revealed none of the above were offered on the resident's tray. The resident received water and coffee on the lunch tray. The resident stated "I did not get any milk."</p> <p>Review of the Dietary Progress Notes, dated 03/25/13, 04/04/13, 05/08/13, 06/03/13, 07/10/13, 08/09/13, 09/06/13, and 10/07/13, revealed the resident should receive a sugar free milkshake and ice cream at lunch and supper to increase caloric intake.</p> <p>Review of the "Altered Food and/or Fluid Intake" care plan, dated 09/11/13, revealed the resident had a history of poor oral intake with a significant weight loss in 180 days. Interventions included to provide the resident with sugar free ice cream and a milkshake at lunch and supper.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1, on 10/10/13 at 12:20 PM, revealed she delivered the lunch tray to Resident #5. She revealed the dietary staff do not always send the resident's "preferences" listed on the tray card; however, if a resident asked for something else, she would get it for them.</p> <p>Interview with the Unit Manager, on 10/11/13 at 10:40 AM, revealed staff were supposed to ensure the diet was correct for the resident when passing trays; however, residents do not usually receive all preferences listed. She revealed the aides passing the trays would not know if the ice cream and milkshake were weight loss interventions as they were not listed as such on the tray card.</p> <p>Interview with the Clinical Dietician, on 10/10/13</p>	F 360			

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F 360	Continued From page 7 at 12:25 PM, revealed dietary staff were supposed to ensure the preferences were sent on the resident meal trays. Interview with the Registered Dietician, on 10/11/13 at 10:50 AM, revealed milk shakes and ice cream were interventions typically ordered for weight loss. She revealed staff should be aware of such interventions. She indicated it would be good for Resident #5 to receive the milkshake and ice cream at lunch and supper to increase caloric intake; however, his/her weight was stable at this time. Interview with the Dietary Manager, on 10/11/13 at 11:05 AM, revealed she expected dietary staff to ensure the ice cream and milkshake was on the resident's tray, if listed as a preference. She indicated preferences were supposed to be followed for all meals. The dietary manager verified there was no way to differentiate between a "weight loss intervention" and a "preference" by looking at the tray card. Interview with the Director of Nursing (DON), on 10/11/13 at 11:40 AM, revealed the care plans indicate weight loss interventions for each resident, and should be followed by staff. She revealed dietary staff should ensure these interventions were followed for each resident.	F 360			
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced	F 372	NHC-Glasgow does dispose of garbage and refuse properly.		

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F 372	Continued From page 8 by: Based on observation and interview, it was determined the facility failed to ensure proper disposal of garbage by placing dumpsters on a washable surface. The findings include: Observation, on 10/11/13 at 9:50 AM, revealed (1) dumpster located on a grass surface. Interview with the Administrator, on 10/11/13 at 11:45 AM, revealed there was no policy related to the garbage dumpsters. He was not aware the dumpsters should be on a washable surface.	F 372	A bid has been attained and accepted for the pourage of a concrete pad under the dumpster. All dumpsters will be placed on concrete pads. Dumpsters will be checked weekly for six weeks and then monthly for three months by maintenance supervisor to ensure all dumpsters are placed on concrete pad, then as determined by Quality Improvement Committee, ADM,DON, Medical Director, Social Services, Health Information , and Quality Improvement Coordinator.	11/15/13
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		

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F 441	<p>Continued From page 9</p> <p>isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy/procedure review it was determined the facility failed to ensure appropriate handwashing was conducted during resident care for one (1) of twenty-nine sampled residents (Resident #4).</p> <p>The findings include:</p> <p>Review of the facility's handwashing policy, last revised 10-01-08, revealed hand hygiene has been cited frequently as the single most important practice to reduce the transmission of infectious agents.</p> <p>Observation on 10/10/13 at 9:25 AM revealed Resident #4 was receiving a bed bath from Certified Nurse Aide (CNA) #2. Resident #4 was incontinent of both bowel and bladder. The CNA was wearing gloves and stopped the bed bath to provide incontinent care to the resident, however,</p>	F 441	<p>NHC-Glasgow does maintain an Infection Control Program designed to provide a safe, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Resident # 4 was observed with no adverse effects.</p> <p>CNA was in -serviced on hand washing and incontinent care with emphasis on changing of gloves by Unit Manager.</p> <p>A random sampling of direct care staff monitored with no identified concern.</p> <p>DON or Designee to In-service nursing staff on proper hand washing and glove changing.</p> <p>DON or Designee will initiate a Quality Improvement monitor of 20 nursing partners per week for hand washing and appropriate glove changing weekly for 6 weeks, then as determined by Quality Improvement Committee, ADM, DON, Medical Director, Social Services, Health Information, and Quality Improvement Coordinator.</p>	11/15/13	

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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 10/11/2013
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW			STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141		
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F 441	Continued From page 10 the CNA did not remove the contaminated gloves and wash her hands after completing the incontinent care. The CNA continued to provide the bed bath and applied lotion to the resident's body while wearing the contaminated gloves. Interview with CNA #2 , on 10/10/13 at 9:25 AM, revealed she had not been told to remove gloves and wash hands between procedures. Interview with the Director of Nursing, on 10/11/13 at 12:20 PM, revealed she expected the CNAs to change gloves anytime they are soiled when providing care. The DON stated she made rounds to ensure staff were following the facility protocol for handwashing.	F 441			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure each bathroom available for resident use was equipped to receive resident calls through a communication system. The findings include: Review of the Call Light policy, undated, revealed a call light alerted staff to a patient's request for	F 463	NHC-Glasgow nurses' station are equipped to receive residents calls through a communication system from resident rooms; and toilet and bathing facilities. The maintenance supervisor has locked the one bathroom door located on the hallway of station (1). A key is provided at the nurse's station for staff to have access to bathroom. The maintenance supervisor locked the two bathrooms in the front lobby, and provided keys to be kept at the receptionist desk. Signs were placed at the bathroom doors notifying visitors to ask for key from receptionist desk.	11/15/13	

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F 463	Continued From page 11 help. Observation, on 10/11/13 at 9:50 AM, revealed two (2) bathrooms in the front lobby and one (1) bathroom located in the hallway of Station (1) without an emergency communication system in place. All three bathrooms were unlocked and available for resident use. Interview with the Administrator, on 10/11/13 at 11:45 AM, revealed all three bathrooms were accessible to residents; however, the front lobby bathrooms were mostly used by the public.	F 463	The maintenance supervisor will monitor bathroom doors weekly for six weeks to assure compliance, then as determined by Quality Improvement Committee, ADM,DON, Medical Director, Social Services, Health Information , and Quality Improvement Coordinator.		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to provide a safe and sanitary environment for residents, staff, and the public. The findings include: Review of the policy for Maintaining Housekeeping Equipment, undated, revealed a mop in storage should be hung with the yarn away from the wall, with the strands down. Observation in the laundry, on 10/09/13 at 1:40 PM, revealed the following:	F 465	NHC-Glasgow does provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.		

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F 465	<p>Continued From page 12</p> <ol style="list-style-type: none"> 1. (1) mop stored beside a washing machine with the mop head on the floor 2. (1) broom and (1) dust mop beside a linen cart, head on the floor (with grayish/white particles noted) 3. (1) broom stored in the corner, head on the floor <p>Observation of the facility, on 10/11/13 at 9:50 AM, revealed the following items stored improperly (head on floor):</p> <ol style="list-style-type: none"> 1. (1) broom stored in the janitor's closet on Station (1) 2. (1) broom stored in the day room on Station (2) 3. (1) dust mop, (1) mop, (1) broom stored in the janitor's closet (to basement) on Station (2) 4. (2) brooms in the other janitor's closet on Station (2) 5. (1) broom located in the janitor's closet on Station (3) 6. (1) dust mop in the storage room on Station (3) 7. (1) dust mop in the storage room on Station (4) 8. (1) dust mop in the janitor's closet on Station (4) <p>Interview with the Housekeeping Supervisor, on 10/11/13 at 10:30 AM, revealed dust mops, mops, and brooms were not supposed to be stored with their heads on the floor. She revealed staff should store them upright to ensure they were clean for the next day.</p> <p>Interview with the Administrator, on 10/11/13 at 11:45 AM, revealed he expected staff to follow the policy related to storage of housekeeping equipment.</p>	F 465	<p>Mops, dust mops, and brooms were hung with heads up on 10/11/13 at direction of Housekeeping/ Laundry Supervisor.</p> <p>No other manual equipment identified with storage issue.</p> <p>Housekeeping and Laundry partners were in-serviced on storage of Housekeeping manual equipment by Housekeeping/Laundry Supervisor.</p> <p>Housekeeping/ Laundry Supervisor will initiate monitor of mops, dust mops, and broom storage monitor 3 times a week, for 6 weeks, and then monthly for 3 months, then as determined by Quality Improvement Committee, ADM,DON, Medical Director, Social Services, Health Information , and Quality Improvement Coordinator.</p>	11/15/13	

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F 465	<p>Continued From page 13</p> <p>2. Review of the facility policy titled, Storage of Medications, dated revised 12/09, revealed documentation of: Potentially harmful substances such as urine test reagent tablets, household poisons, cleaning supplies and disinfectants are clearly identified and stored in a locked area separately from medications.</p> <p>Observation during a medication pass on 10/10/13 revealed batteries were stored in the medication cart and were laying on top of suppositories and nasal sprays. There were eight AA batteries, four AAA batteries and one 9-volt battery.</p> <p>Review of the Material Safety Data Sheet (MSDS) for alkaline batteries revealed: CAUTION: May explode or leak and cause burn injury and do not carry batteries loose.</p> <p>Review of the battery container revealed a caution warning: "May explode or leak and cause burn injury"</p> <p>An interview with Licensed Practical Nurse (LPN) #2, at the time of the observation revealed batteries were normally stored in a drawer at the nursing station and not in the medication cart. Batteries laying on medications was not an ideal situation.</p> <p>An interview with the Director of Nursing (DON), on 10/10/13 at 10:50 AM, revealed there was not a facility policy related to the storage of batteries. She stated batteries were normally kept at the nursing station. She felt there was not a problem as long as the batteries did not leak but could not ensure that batteries stored with medications</p>	F 465	<p>Batteries stored on medication cart were removed promptly by nurse supervisor and store separately in medication room drawaer.</p> <p>Med- cart nurse was in-serviced on separating medication and potentially harmful substances by RN Supervisor.</p> <p>No other medication cart was found or identified to have improper storage of harmful substances.</p> <p>DON or Designee will in-service nurses of proper storage of medications.</p> <p>DON or Designee will conduct Quality Improvement monitor weekly for four weeks, then monthly for three months,</p>	11/15/13	

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F 465	Continued From page 14 would never leak.	F 465	then as determined by Quality Improvement Committee, ADM,DON, Medical Director, Social Services, Health Information , and Quality Improvement Coordinator.		

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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW	STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141
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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/20/13 as alleged.</p>	{K 000}		
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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.

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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW	STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968, 1976</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (211)</p> <p>SMOKE COMPARTMENTS: Ten smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with 19 heat and 250 smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.</p> <p>GENERATOR: Type II Caterpillar generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was initiated on 10/09/2013. NHC Healthcare, Glasgow was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for 194 beds with a census of 187 on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	The plan of correction is submitted as required under the State and Federal Law. The facility's submission of the Plan of Corrections does not constitute as admission on the part of the facility that the findings constitute deficiency, or the scope and severity determination is correct.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Admin.* (X6) DATE *11/4/13*

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

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K 000	Continued From page 1	K 000		
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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 seven (7) of ten (10) smoke compartments, all residents, staff and visitors. The facility is certified for 194 beds with a census of 187 on the day of the survey. The facility failed</p>	K 018	NHC - Glasgow doors do protect corridor opening and resist the passage of smoke.	

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K 018	<p>Continued From page 2</p> <p>to ensure four (4) resident doors could be closed with a single motion.</p> <p>The findings include:</p> <p>Observations, on 10/09/13 between 9:30 AM and 11:00 AM with the Maintenance Supervisor, revealed the corridor doors to the resident rooms were blocked from closing due to the bathroom doors. The resident bathroom doors throughout the facility could extend open and block the resident doors from closing. The examples of this were rooms #125, 150, 145, and 101.</p> <p>Interviews, on 10/09/13 between 9:30 AM and 11:00 AM with the Maintenance Supervisor, revealed he were unaware the doors were blocking the resident doors from closing properly.</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 13/4-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 for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p>	K 018	<p>Maintenance Supervisor order a spring closure to mount to bath room doors. They were placed on six doors on 10/28/13 to ensure proper effectiveness. Maintenance Supervisor will order more spring closures on 10/29/13 for remaining doors on all resident bathroom doors on Nursing Stations 3 and 4.</p> <p>Maintenance Supervisor inspected bathroom doors on Stations 1 and 2 for proper operation, and they worked properly. Maintenance Supervisor will monitor doors for proper operation weekly for six weeks, then monthly for 3 months, then as determined by Quality Improvement Committee, ADM, DON, Medical Director, Social Services, Health Information, and Quality Improvement Coordinator.</p>	11/20/13

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K 018	Continued From page 3 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 at 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 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 025	NHC-Glasgow smoke barriers are constructed to provide at least one half -hour fire resistance rating in accordance with 8.3.	

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K 025	<p>Continued From page 4</p> <p>separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on 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 nine (9) of ten (10) smoke compartments, all residents, staff and visitors. The facility is certified for 194 beds with a census of 187 on the day of the survey. The facility failed to ensure six (6) smoke barriers were sealed around pipes and wires to resist the passage of smoke.</p> <p>The findings include:</p> <p>Observations, on 10/09/13 between 9:30 AM and 11:00 AM with the Maintenance Supervisor, revealed the smoke partilions, extending above the ceiling located at dining room, room 100, 112, 129, and 149, were penetrated by pipes, steel beams, and wires. Further observation revealed the wall at room 35 did not extend to the roof decking.</p> <p>Interview, on 10/09/13 between 9:30 AM and 11:00 AM with the Maintenance Supervisor, revealed they were unaware of the penetrations in the smoke barriers. Further interview revealed he was fairly new to the facility and had not had</p>	K 025	<p>The maintenance supervisor repaired penetration at dinning room, room 100, 112,129, and 149. The wall has also been extended to the roof deck at room 35. This work was done on 10/16/13 and 10/17/13.</p> <p>The maintenance supervisor will check all smoke walls for penetrations and repair as needed.</p> <p>The maintenance supervisor will monitor monthly for three months, then quaterly on going, then as determined by Quality Improvement Committee, ADM,DON, Medical Director, Social Services, Health Information , and Quality Improvement Coordinator.</p>	11/12/13

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K 025	Continued From page 5 the time to do extensive checking of the smoke barriers throughout the facility. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (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. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining	K 025		

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K 025	Continued From page 6 the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025	NHC- Glasgow is one hour fire rated construction with 3/4 fire-rated doors.		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, twenty-eight (28) residents, staff and visitors. The facility is certified for 194 beds with a census of 187 on the day of the survey. The facility failed to ensure the medical records office was self-closing. The findings include: Observations, on 10/09/13 at 9:45 AM with the	K 029			

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K 029	<p>Continued From page 7</p> <p>Maintenance Supervisor, revealed the door to the medical records office was propped open with a door wedge which prevented the self-closing device to keep the area separate from the facility.</p> <p>Interview, on 10/09/13 at 9:45 AM with the Maintenance Supervisor, revealed he was unaware the door wedge was in use.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous</p>	K 029	<p>The maintenace supervisor removed wedge used to prop open door on 10/9/13. The maintenance supervisor in-serviced the Medical Record Dept. Head on not propping door open.</p> <p>The maintenance supervisor inspected other doors to ensure none were propped open.</p> <p>The maintenance supervisor will monitor doors not being propped open weekly for 6 weeks, then monthly for 3 months, then as determined by Quality Improvement Committee, ADM,DON, Medical Director, Social Services, Health Information , and Quality Improvement Coordinator.</p>	11/15/13

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K 029	Continued From page 8 by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 066 SS=D	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	NHC-Glasgow prohibits smoking in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored. Smoking is prohibited by patients classified as not responsible. Ashtrays of noncombustible materials and safe design are provided in smoking areas. Metal containers with self-closing cover devices into which ashtrays can be emptied are available.	

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K 066	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, residents, staff and visitors. The facility is certified for 194 beds with a census of 187 on the day of the survey. The facility failed to ensure the metal cigarette bucket contained no trash and only proper ashtrays were in use at the smoking area.</p> <p>The findings include:</p> <p>Observation, on 10/09/13 at 3:20 PM with the Maintenance Supervisor, revealed the smoking area had a proper metal container to dump the ashtrays into but the bucket was full of trash and cigarette butts. Further observation revealed the concrete vases were being used as ashtrays and they did not have a self-closing lid.</p> <p>Interview, on 10/09/13 at 3:20 PM with the Maintenance Supervisor, revealed he was unaware of the trash being placed in the metal container and that the concrete vases could not be used as ashtrays.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other</p>	K 066	<p>The maintenance supervisor removed the concrete vases on 10/11/13.</p> <p>Housekeeping supervisor will do an in-service with the housekeeping dept. to ensure all partners are aware that no trash should be in metal containers.</p> <p>The housekeeper assigned to the smoking area will check metal container twice a day. A sign will be placed on the metal container by the maintenance supervisor stating, "Cigarette butts only. No trash."</p> <p>The housekeeping supervisor will monitor daily for three weeks, then weekly for three weeks for compliance, then as determined by Quality Improvement Committee, ADM, DON, Medical Director, Social Services, Health Information, and Quality Improvement Coordinator.</p>	11/10/13	

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K 066	Continued From page 10 hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, all residents, staff and visitors. The facility is certified for 194 beds with a census of 187 on the day of the survey. The facility failed to ensure the generator was being operated under load once a month and the transfer switch was operated monthly. The findings include: Observation, on 10/09/13 at 11:35 AM with the Maintenance Supervisor, revealed the generator was not being exercised under load on a monthly basis. Interview, on 10/09/13 at 11:35 AM with the Maintenance Supervisor, revealed he was aware the generator was to be exercised under load monthly but the previous Administrator had instructed them to not exercise the generator due to the transfer switch being obsolete. Further interview revealed the generator had not been under a monthly load since he started in March of 2013. Observation, on 10/09/13 at 11:35 AM with the Maintenance Supervisor, revealed the transfer switch had not been operated since before March of 2013.	K 144	On 10/12/13 the company which provides maintenance on the generator and back-up system, conducted a test on the generator. Generator worked correctly. They in-serviced the maintenance supervisor on the proper way to conduct this test. They also inspected the transfer switches and found no problems. The maintenance supervisor will test the generator underload monthly. The maintenance supervisor will monitor monthly on-going for compliance, then as determined by Quality Improvement Committee, ADM, DON, Medical Director, Social Services, Health Information, and Quality Improvement Coordinator.	10/21/13

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K 144	<p>Continued From page 12</p> <p>Interview, on 10/09/13 at 11:35 AM with the Maintenance Supervisor, revealed he was aware the transfer switch was to be operated monthly but the previous Administrator had instructed them to not operate the transfer switch due to the transfer switch being obsolete. Further interview revealed the previous Administrator was concerned if the generator transfer switch had been operated it might not switch back to normal power.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>6-4.5* Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p>	K 144		

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K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, residents, staff and visitors. The facility is certified for 194 beds with a census of 187 on the day of the survey. The facility failed to ensure one (1) electrical panel maintained three (3) feet of clearance around them.</p> <p>The findings include:</p> <p>Observations, on 10/09/13 at 11:50 AM with the Maintenance Supervisor, revealed the electrical panel in the food service directors ' office had a bookshelf within 3 feet of the electrical panels.</p> <p>Interview, on 10/09/13 at 11:50 AM with the Maintenance Supervisor, revealed he was unaware the bookshelf was not properly installed to allow clearance to the electrical panel..</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be</p>	K 147	<p>The maintenance supervisor removed the bookshelf on 10/14/13. The maintenance supervisor check other electrical panels for compliance and found no issues. All dept heads will be in-serviced by the maintenance supervisor for awareness that no item should be placed with in 3 feet of electrical panels .</p> <p>The maintenance supervisor will conduct a Q&A weekly for six weeks, then monthly for 3 months to ensure compliance, then as determined by Quality Improvement Committee, ADM,DON, Medical Director, Social Services, Health Information , and Quality Improvement Coordinator.</p>	11/15/13	

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K-147	<p>Continued From page 14</p> <p>provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td colspan="2">1 m (3½ ft)</td> </tr> <tr> <td></td> <td colspan="3">1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick,</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)			1.2 m (4 ft)			K 147		
Nominal Voltage to Ground	Minimum Clear Distance																							
Condition 1	Condition 2	Condition 3																						
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K 147	Continued From page 15 or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between. (a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all un-insulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or	K 147		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2013
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW			STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141	
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K 147	Continued From page 16 platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the	K 147		

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K 147	Continued From page 17 equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.	K 147		