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

PRINTED: 06/21/2010
FORM APPROVED
OMB NO. 0938-0391

RECEIVED JUN 2010 OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 06/09/10
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P.O. BOX 189 GLASGOW, KY 42141	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Rec 6/30/10	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An on-site revisit was conducted on 06/08-09/10 to determine the facility's compliance with Federal Regulatory Requirements. Deficiencies were identified with the highest S/S being a "D".	F 000	POC #2 is accepted - Admin made awareness Holloway	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F157	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. Physician was notified of resident #19 foul urine odor on 6/08/10. On 6/10/10 the physician ordered an antibiotic, resident was placed on intake & output, vital signs were obtained every shift and she was monitored for signs and symptoms of adverse reactions to antibiotic therapy for seven days. Interdisciplinary care team reviewed and revised resident #19 care plans and assignment sheet on 6/16/10 to monitor for any signs and symptoms of a urinary tract infection. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An incident report is completed by the licensed nurse when a resident experiences a change in condition. The incident report is completed on the shift of occurrence and the form provides space for documentation of notification of the physician. In the event the nurse is unable to contact the physician by the end of his/her shift, the oncoming shift is responsible to follow-up with the physician and document on the incident report. The Director of Nursing or day shift RN will review the 24 hour inter-shift matrix (24 hour nursing report for all three residential units) every morning to ensure an incident report has been completed and the physician has been notified for all residents with a change in condition. The Matrix will be retained at the nurses' station for 72 hours in a designated binder and then given to receptionist's office to be maintained for period of (1) year.	07/06/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Tandy	Director	6/29/10

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

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	185363		06/09/2010
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P. O. BOX 189 GLASGOW, KY 42141	

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to ensure the physician was notified related to a change in condition that could indicate a need to alter treatment for one resident (#19), in the selected sample of nine. The facility noted Resident #19 had developed a foul odor to his/her urine, on 06/02/10, however, the facility failed to notify the resident's physician for six days. The facility notified the physician on 06/08/10. Findings include. A review of the facility's policy/procedure entitled, "Changes in a Resident's Condition or Status," dated revised 09/2007, revealed "the Nurse Supervisor (RN) or Unit Charge Nurse (LPN) will notify the on-call physician or physician making daily rounds when there is a significant change in the resident's physical, mental or psychosocial status and there is a need to alter treatment significantly. Except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's condition or status." A review of the facility's plan of correction (POC), received 05/26/10, with an alleged compliance date of 06/01/10, revealed "an incident report is completed by the licensed nurse when a resident experiences a change in condition. The incident report is completed on the shift of occurrence and the form provides space for notification of the physician. The Incident Management Committee reviews all resident incidents from the previous 24 hours, including incidents involving a resident's	F 157	New admissions to the facility will have a Bladder Assessment completed by a licensed nurse with a 72 hour Bladder Record initiated to record the time the resident voided and whether he/she was incontinent. If the resident is noted to have foul smelling urine or any other possible sign and symptom of a UTI, the licensed staff member will document findings in the medical record, document on the 24 hour inter-shift matrix form, complete an incident report, initiate alert charting for 72 hours, and notify the physician. All residents will have a Bladder Assessment completed quarterly or with a significant change in condition and the interdisciplinary team will develop individualized care plans based on the results of the Bladder Assessment. If the licensed staff member notes the resident has foul smelling urine or any other possible sign and symptom of a UTI while completing the Bladder Assessment, he/she will contact the physician; initiate alert charting for 72 hours, and document on the 24 hour inter-shift matrix and in the respective medical record. The Dietitian reviewed seventy-four residents' fluid consumption for the past seven days and compared their consumption with their estimated individual fluid needs on 6/25/10. The physician was notified of any resident who was not consuming their estimated needs. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Alert charting is initiated for new admissions and/or readmissions to the facility and when an incident report is completed for a change in condition which requires observation by all shifts. The licensed nurse will assess the resident and document resident's response to treatment and applicable staff interventions in the nurses' notes on every shift for seventy-two hours unless the condition warrants monitoring for longer than seventy-two hours. The nursing policy "Alert Charting" was revised on 6/16/10 to specifically include "notifying the physician regarding change in a resident status as well as notifying the RN Charge Nurse/DON". The nursing policy "Inter-shift Reporting and Documentation" was revised on 6/17/10 to clearly communicate expectations of licensed staff responsible for the supervision of and provision of maintenance care or medical treatment of our residents.	

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F157	Continued From page 2 change in condition, Monday through Friday, and the day shift RN reviews the incidents, Saturday through Sunday. The Director of Nursing is a member of the Incident Management Committee and is responsible for ensuring a resident's change in condition is communicated to the physician." A record review revealed Resident #19 was admitted to the facility, on 06/25/09, with diagnoses to include Dementia with Behavioral Disturbance and Alzheimer's Disease. A review of a quarterly Minimum Data Set (MDS), dated 03/24/10, revealed the facility identified Resident #19 as incontinent of bowel/bladder and totally dependent on staff for hygiene and toileting needs. Further review of a bladder assessment dated, 03/15/10, revealed the facility assessed the resident to have functional incontinence. A review of nursing notes, dated 06/02/10 at 3:00 AM revealed "staff reports urine has foul smell, placed on alert charting". An entry, dated 06/04/10 a 3:00 AM and 10:50 AM, revealed a foul odor to urine continued. An entry, dated 06/05/10 at 11:10 AM, revealed a report of a foul odor to urine. There was no evidence the physician was notified regarding the change in status for Resident #19. An interview with Licensed Practical Nurse (LPN) #1, on 06/09/10 at 3:30 PM, revealed she had noted no foul odors of the resident's urine during her shift on 06/05/10, however, the resident's name should have been placed on the physician's clipboard, due to the noted change in condition, when foul smelling urine was first noted. An interview with the Infection Control Nurse,	F157	All licensed staff (state and contract) will be in-serviced on the nursing policies "Alert Charting" and "Inter-shift Reporting and Documentation" as well as applicable forms by 07/01/10. All newly hired licensed staff (state and contract) and licensed employees returning from leave will be in-serviced on all three policies prior to returning to their assigned shift. "Checklist for Proper Nursing Assessment for Certain Clinical Problems" was developed as a competency tool for licensed staff. The staff development coordinator will review the outlined scenarios with all licensed staff (state and contract) by 07/01/10 and will provide individualized feedback if they require additional training. All newly licensed staff (state and contract) and licensed employees returning from leave will be in-serviced on the competency checklist prior to returning to their assigned shift. Indicate how the facility plans to monitor its performance to ensure the solutions are sustained. The Incident Management Committee (consisting of the Facility Director, Facility Superintendent Associate, Director of Nursing, Risk Manager, Social Service Director, Administrator on Call, and/or day shift RN) reviews all resident incidents from the previous 24 hours including incidents involving resident's change in condition Monday-Friday and the day shift RN reviews the incidents Saturday-Sunday. The Director of Nursing is a member of the Incident Management Committee and is responsible for ensuring resident's change in condition is communicated to the physician. All resident incidents are entered into an internal facility database for analytical review. The Risk Manager will compile a weekly synopsis of all resident incidents and forward the report to the incident management committee members by Friday. The Director of Nursing or Facility Superintendent Associate will ensure the physician was notified of all resident related incidents by the following Tuesday. Any identified discrepancies will be immediately addressed by the Director of Nursing or Facility Superintendent and submitted to the Risk Manager for inclusion in the facility database. The Risk Manager or Director of Nursing will present the total number of physician notifications compared to the total number of resident incidents to the Monthly CQI/QA Committee. The Director of Nursing or the	

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F 157	Continued From page 3 on 06/09/10 at 2:00 PM, revealed she was responsible for tracking all infections. The resident was identified as having no prior history of urinary tract infections. An interview with Registered Nurse (RN) #1, on 06/09/10 at 2:55 PM, revealed she was unaware of the urine odor. However, she completed a random audit, on 06/08/10, on Resident #19's chart. RN #1 stated she notified the physician on 06/08/10 and received orders for a "stat (immediate) urinalysis (UA), culture and sensitivity (C&S) if indicated, send to hospital lab. Encourage fluids pending UA & C&S." The resident was placed on alert charting, I & O and vital signs, pending UA results. An interview with the Director of Nursing (DON), on 06/08/10 at 1:30 PM, revealed the reason for the alert charting (for 72 hours), was the foul urine odor noted on 06/02/10, which indicated a change in the resident's condition that required monitoring. She stated the resident was on intake and output (I & O), however, this was not a new intervention. The DON could not locate any evidence that an incident report was completed regarding this resident's change in condition, and was unable to provide an explanation as to why it was not completed for a change in condition. A review of the UA (collected by catheterization) results, dated 06/08/10, revealed "character was slightly hazy, white blood cells 6-10 (normal 0-5), and bacteria 2+ (normal absent)."	F 157	Facility Superintendent Associate will address any discrepancies discovered during the weekly reviews. The Facility Director is responsible for reviewing all reports shared at the CQI/QA Committee meeting.	

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Rec 5/24/10 POC #2 Revised Accepted + Revised 5/25/10

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F 000	INITIAL COMMENTS An annual survey and an abbreviated survey (KY #14585) was conducted on 04/20-23/10 to determine the facility's compliance with Federal Regulatory Requirements. Allegation KY #14585 was substantiated. Deficiencies were identified with the highest S/S being a "D".	F 000	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. Physician was notified of resident #13 stoma site drainage on 4/23/10. Interdisciplinary team reviewed and revised resident #13 care plans and nurse aide assignment sheet pertaining to skin care on 4/28/10.	06/01/10
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(c)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F157	Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On admission, residents will have a skin assessment performed by a licensed nurse within twenty-four hours with findings documented on the Initial Nursing Assessment form and Nursing Admission History, Assessment and Initial Plan of care. If the resident has a gastrostomy tube (G-tube) the nurse will observe the stoma site for any drainage, notify the physician if drainage is present and place the resident on alert charting for seventy-two hours to monitor for any possible complications to the stoma site. When residents are designated on alert charting, the issue is noted on the 24 hour inter-shift matrix form. The Director of Nursing or day shift RN will review the matrix every morning to ensure the physician has been notified and the completion of an incident report for all residents with stoma site drainage. Upon admission or placement of a gastrostomy tube, the Enteral Monitoring Form will be initiated by the licensed nurse and completed every shift. The Enteral Monitor Form alerts the nurse to notify the physician and complete an incident report if stoma site drainage is present. All residents with gastrostomy tube (G-tube) were assessed by a RN for possible stoma site drainage on 4/28/10 and any identified issues were reported to the physician. Interdisciplinary team members reviewed and revised care plans and nurse aide assignment sheets on 4/28/10 for all residents with gastrostomy tubes to include monitoring for possible drainage at stoma site and notifying physician of any signs or symptoms of infection.	

Jenna Holloway

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Tandy	Director	5/24/10

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

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure the physician was notified related to a change in condition that could indicate a need to alter treatment for one resident (#13) in the selected sample of 15. Resident #13 developed a green colored draining from the gastrostomy tube (G-tube) site on 04/11/10 and the facility did not notify the physician until 04/23/10. Findings include: A review of the facility policy for "Skin and Stoma Care", dated 04/99, revealed "report any redness, irritation, soreness, or unusual drainage to the physician". Record review revealed Resident #13 was unable to make his/her needs known, was in the bed or the chair most of the time and the resident's needs were anticipated by staff. All the resident's nutritional needs were provided per G-tube. A review of Resident #13's nursing notes, dated 04/04/10 at 3:10 AM, revealed an entry that included "drainage noted at stoma (opening in body for feeding tube) site, red drainage with scant amount of yellow drainage. An entry on 04/11/10 at 6:28 PM, revealed "stoma with greenish colored drainage". On 04/18/10 at 2:45 AM, the nursing note revealed "stoma with greenish colored drainage." On 04/19/10 at 2:25 AM, a nursing note revealed "small amount red green drainage".	F 157	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Enteral Monitoring form was revised on 4/28/10 to include "notify MD and complete Incident Report if change/complications are noted." The Enteral Monitoring form was further refined on 5/22/10 to include "Notify MD and complete Incident Report Form if complications noted at stoma site, i.e. redness, drainage, etc." All residents with gastrostomy tubes (G-tubes) will have the revised Enteral Monitoring Form placed on their medical record by 05/28/10. The Enteral Monitoring form is completed per shift by the licensed nurse for every resident with a gastrostomy tube. The Infection Control Nurse will perform random audits of Enteral Monitoring forms on all three residential units weekly. Identified discrepancies will be reported to the physician and an incident report will be completed. The Infection Control Nurse will also report the information to the Facility Superintendent Associate and/or RN charge nurse at the time of occurrence for applicable staff education. All licensed staff (state and contract) will be in-serviced on the nursing policy "Transabdominal Tube Feedings and Care: Peg Tube, PEJ Tube, Gastrostomy Tube, Gastrostomy Button" by 5/28/10. The policy was revised to include notifying the physician of change in the condition of the stoma site and/or if the resident experiences complications with the gastrostomy tube. All licensed staff members (state and contract) will be in-serviced on nursing policy "Changes in a Resident's Condition or Status" by 5/28/10. The policy states "changes in the resident's condition and/or status shall be promptly reported to the Charge Nurse, his or her physician, the resident and the resident's legal guardian." All newly hired licensed staff (state and contract) and licensed employees returning from medical leave will be in-serviced on both policies prior to returning to their assigned shift. Indicate how the facility plans to monitor its performance to ensure the solutions are sustained. The Infection Control Nurse will forward a copy of her weekly Enteral Monitoring Form audits to the Facility Superintendent Associate and/or the RN charge nurse by the 5th of the following month. The Infection Control Nurse presents her findings of the weekly audits at the monthly CQI/QA meeting and will include the number of residents identified with drainage. The facility director is responsible for all	

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			reports shared at the monthly CQI/QA committee meeting.	
F 157	Continued From page 2 An observation with Licensed Practical Nurse (LPN) #4, on 04/23/10 at approximately 9:30 AM, revealed the stoma site was red with a moderate amount of blood tinged drainage. An interview conducted with LPN #4, on 04/22/10 at approximately 2:20 PM, revealed the resident did not always have drainage around the stoma site. She also stated she was not aware there had been a green color drainage and the physician should have been notified. LPN #4 stated green drainage could be an indication of infection. An interview conducted with the Director of Nursing (DON), on 04/23/10 at approximately 10:10 AM, revealed green colored drainage from a stoma site could indicate infection. Green colored drainage would require the physician to be notified. During an interview with the resident's physician, on 04/23/10 at approximately 9:45 AM, he stated he had not been made aware of the drainage until 04/23/10 and he had given new orders at that time.	F 157	An incident report is completed by the licensed nurse when a resident experiences a change in condition. The incident report is completed on the shift of occurrence and the form provides space for notification of the physician. The Incident Management Committee reviews all resident incidents from the previous 24 hours including incidents involving resident's change in condition Monday-Friday and the day shift RN reviews the incidents Saturday-Sunday. The Director of Nursing is a member of the Incident Management Committee and is responsible for ensuring resident's change in condition is communicated to the physician.	
F315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. The resident was placed on alert charting to monitor for any possible complications of incontinent care and a skin assessment was completed on 4/28/10 with no problems noted. The resident was also monitored for increased temperature 4/21/10-4/25/10 with no elevated temperature noted. The interdisciplinary team members reviewed and revised resident #4 care plans and assignment sheets on 5/12/10 to include provide peri care after all incontinent episodes and as needed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	06/01/10

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NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P. O. BOX 189 GLASGOW, KY 42141	

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F 315	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure one resident (#4), in the select sample of 15, who was incontinent of bowel and bladder, received the appropriate incontinent care to prevent a Urinary Tract Infection. Findings include: Record review revealed Resident #4 was admitted to the facility, on 08/14/79, with diagnosis to include Organic Brain Syndrome Secondary to Hypoxia. The quarterly Minimum Data Set (MDS), dated 02/04/10, revealed the facility assessed the resident as totally incontinent of bowel and bladder, cognitively unable to communicate and dependent on staff for all care needs. The care plan for incontinence, dated 11/12/09, revealed the staff were to check the resident for incontinence and provide incontinent care and briefs, every two hours and as needed. An observation of incontinent care, on 04/21/10 at 1:50 PM, revealed Certified Nurse Aide (CNA) #1 was assisting CNA #2 during incontinent care for Resident #4. CNA #1 used a wet wash cloth to wash the resident's anal area and buttocks in a back and forth motion. The CNA then used the same wash cloth, that was smeared with stool and washed the resident's penis. During an interview with CNA #1, on 04/21/10 at 1:55 PM, she stated she knew better and was trained better, but was nervous. An interview, on 04/21/10 at 2:00 PM, with Licensed Practical Nurse (LPN) #3 revealed she	F 315	On admission, a licensed nurse assesses the resident for bladder continence within twenty-four hours with findings noted on the Bladder Assessment Form. The care plan and nursing assignment sheet are devised according to the bladder assessment. Review of urinary continence is completed quarterly or with a change in condition. C.N.A #1 was in-serviced on correct perineal care for incontinent residents on 4/22/10. Perineal Care competency checks will be completed for sixty one nursing assistants by 5/28/10 by RN supervisors. The competency checks were completed utilizing a manequin or observing direct resident care. Certified Nursing Assistants (state and contract) will complete competency during orientation and annually on peri care to ensure residents who are incontinent of bladder will receive appropriate care. The interdisciplinary team reviewed and revised care plans and assignment sheets of all forty-nine residents incontinent of bowel and bladder on 5/14/10. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Nursing policy "Perineal Care" revised on 4/28/10 specifically outlines the appropriate procedure for providing perineal care to the male and female resident. All nursing staff was in-serviced on the policy on 5/14/10. All newly hired nursing assistants (state and contract) and nursing assistants returning from medical leave will be in-serviced on this policy prior to returning to their assigned shift. Indicate how the facility plans to monitor its performance to ensure the solutions are sustained. Checklists "Perineal Care for the Female Resident" and "Perineal Care for the Male Resident" were devised 4/28/10 as a competency tool for nurse aides. RN supervisors will address any identified concerns with the nursing assistants at the time of the competency review. The Director of Nursing will ensure seven nursing assistants per month are observed providing peri care utilizing the "Perineal Care for the Female/Male Resident" with findings being presented at the monthly CQI/QA committee meeting. The facility director is responsible for reviewing all reports shared at the monthly CQI/QA committee meeting.	

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

PRINTED: 05/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 04/23/2010
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P. O. BOX 189 GLASGOW, KY 42141	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 4 and the CNAs used disposable peri-wipes that were kept on the linen carts for incontinent care and the CNAs usually utilized several wipes at a time. A review of the policy and procedure for perineal care, dated June 2002, revealed the staff members were to position the resident to expose the soiled area and remove the bulk of fecal matter. Perineal solution was to be sprayed onto a warm, wet wash cloth and soiled areas were to be cleaned, cleaning front to back and rinsing the area with warm water and patting the area dry. An interview, on 04/23/10 at 11:05 AM, with the DON revealed the DON had been made aware of the improper incontinent care and CNA #1 was sent back through retraining with the Staff Development Coordinator after the surveyor's observation.	F 315	The infection control nurse monitors all resident infections weekly and presents a report at the interdisciplinary COI/QA committee meeting monthly. If trends are identified with a specific infection, resident, residential floor, etc. she will notify the Facility Superintendent Associate and/or the day shift RN.	
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 observations, interviews and record reviews, it was determined the facility failed to ensure it was free of a medication error rate of 5% or greater. Observations of medication passes revealed 48 opportunities were observed with three errors, which resulted in a 6% medication error rate. Finding include: 1. Observation of a medication pass, on	F 332	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. Physician and pharmacist were notified of Resident #21 extra eye drop instillation on 4/21/10 with no adverse reactions noted. Physician and pharmacist were notified on 4/24/10 of Resident #19 missed dose of medication with no adverse reactions noted. Physician and pharmacist were notified of medication given out of timeframe on 4/24/10 for Resident #20 with no adverse reactions noted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receive medications and could have the potential to be affected by the deficient practice. In the event of a medication error the licensed nurse will immediately assess the resident, contact the physician, pharmacist and guardian. After the completion of the nursing assessment, the licensed nurse will complete an	06/01/10

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 185163	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/23/2010
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P. O. BOX 189 GLASGOW, KY 42141	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 5 04/20/10 at 4:05 PM, revealed Licensed Practical Nurse (LPN) #1 administered Restasis 0.05% eye emulsion two drops (gtt.) to each eye of Resident #21. However, review of the physicians orders, dated 03/30/10 and the April 2010 Medication Administration Record (MAR), revealed the resident should have received Restasis 0.05% one gtt. to each eye. An interview with LPN #1, on 04/20/10 at 5:45 PM, revealed when she looked at the MAR she immediately realized she should have administered only one gtt. in each eye. She stated she was confused because the order had been changed so many times. 2. An observation of a medication pass, on 04/21/10 at 1:15 PM, revealed LPN #2 administered only one medication, Calcium with Vitamin D 600 milligrams (mg.) to Resident #19. However, review of the physician's orders, dated 03/2010 and the April 2010 MAR, revealed the facility was to administer Seroquel 100 mg. at 2:00 PM. An interview with LPN #2, on 04/22/10 at 9:10 AM, revealed she must have overlooked the Seroquel on the MAR when she administered the 2:00 PM medications. 3. An observation of a medication pass, on 04/22/10 at 9:10 AM revealed LPN #2 administered Ferrous Sulfate (iron) 325 mg. by mouth to Resident #20. However, review of the physician's order, dated 03/2010 and April 2010 MAR, revealed the Ferrous Sulfate should have been administered with a meal at 7:30 AM. An interview with LPN #2, on 04/22/10 at 9:10	F 332	Incident report on the shift of occurrence and initiate alert charting for seventy-hours to monitor for any adverse reactions. The licensed nurse will notify the Director of Nursing or RN charge nurse of the medication incident. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Medication observations will be completed for all licensed staff (state and contract) and CMTs by 5/28/10 using the "Medication Administration Performance" tool. All newly hired licensed staff (state and contract) and CMTs and licensed staff and CMTs returning from medical leave will complete medication observation prior to returning to their assigned shift. All licensed staff (state and contract) and CMTs will be in-serviced on the newly implemented nursing policy "one Pack Packaging" by 5/28/10. Additionally, licensed staff (state and contract) and CMTs were will be in-serviced on nursing policies Medication Administration Record (MAR CARD), Medication Administration General Rules, Administering Eye Medications, and Medication Pass-Time Schedule by 5/28/10. All newly hired licensed staff (state and contract) and CMTs and licensed staff and CMTs returning from medical leave will be in-serviced on the policies prior to returning to assigned shift. All licensed staff (state and contract) and CMTs will view the taped presentation conducted by the contract pharmacist on the PacMed system by 5/28/10. Also, licensed (state and contract) staff and CMTs will view the taped presentation of Fundamentals of Medication Administration conducted by a KCTCS instructor by 5/28/10. All newly hired licensed staff (state and contract) and CMTs and licensed staff and CMTs returning from medical leave will be in-serviced on both presentations prior to returning to their assigned shift. Indicate how the facility plans to monitor its performance to ensure the solutions are sustained. An incident report is completed for medication errors during the shift of discovery. The Incident Management Committee meets Monday-Friday and reviews all incidents from the previous 24 hours and incidents will be reviewed Saturday-Sunday by day shift RN charge nurse. The Director of Nursing is responsible for reviewing all medication errors.	

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 185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 03/23/2010
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P. O. BOX 189 GLASGOW, KY 42141	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 6 AM, revealed she failed to give the Ferrous Sulfate at 7:30 AM, so she gave it with the 9:00 AM medication pass. She stated she was aware it was supposed to be given with a meal.	F 332	"Medication Performance Checklist for Selected Medications and Techniques" was devised on 5/13/10 and will be utilized as a medication observation tool targeting eye drop instillation, metered-dose inhalers, and G-tube medications. The Director of Nursing or Facility Superintendent Associate will ensure fourteen random medication observations are completed monthly of licensed staff (state or contract) and/or CNA's by RN supervisors. Any identified discrepancies will be corrected at the time of occurrence. The RN charge nurse will educate staff on appropriate techniques and complete an incident report if issues are noted. The Director of Nursing will present the findings of the random medication observations at the monthly Interdisciplinary CQI/QA committee meeting. Medication errors are reviewed by the Director of Nursing or day shift RN charge nurse at the monthly Interdisciplinary CQI/QA committee meeting to discuss possible measures implemented to prevent recurrence. The facility director is responsible for reviewing all reports shared at the monthly CQI/QA committee meeting.	

MEDICATION PERFORMANCE CHECKLIST FOR SELECTED MEDICATIONS & TECHNIQUES

Name:		
	Eyedrops Instillation	**Checkoff**
1.	Get medication out of cart; check the 10 rights x 3.	☐
2.	Verify prescribed number of drops.	☐
3.	Wash hands and put on gloves.	☐
4.	Identify the resident and yourself and explain the procedure.	☐
5.	Position resident, either lying down or sitting in a chair with head back, and instruct the resident to look up.	☐
6.	Pull the lower lid gently to expose the conjunctival sac with the nondominant hand.	☐
7.	With the dominant hand resting gently on the resident's forehead, hold the dropper ½ to ¾ inch above the conjunctival sac.	☐
8.	Drop prescribed number of drops into the conjunctival sac (not directly onto the eyeball).	☐
9.	Remove gloves and wash hands.	☐
10.	Chart administration of medication.	☐
11.	If two (2) different eyedrops are ordered, wait 5 minutes between administration (per pharmacist).	☐

NOTE: If administering a drug that has systemic effect, use a tissue and gently press against the inner corner of the eye and bone of the nose for 30-60 seconds. This is to keep the medication from entering the tear duct and nose.

Comments: _____

Name:		
	Metered-Dose Inhalers	**Checkoff**
1.	Get medication out of cart. Check 10 rights x 3.	☐
2.	Wash hands and put on gloves.	☐
3.	Identify patient and yourself, and explain the procedure.	☐
4.	Assist resident into either sitting or lying position for administration.	☐
5.	Shake inhaler and then hold upright.	☐
6.	Instruct resident to place mouthpiece of inhaler or spacer in their mouth.	☐
7.	Tell the resident to press down on the inhaler while INHALING.	☐
8.	Tell resident to breathe in slowly for 2-3 seconds, then hold breath for 10 seconds.	☐
9.	Wait one minute before giving additional puffs.	☐
10.	If two (2) inhaled meds are ordered, wait 1-2 minutes between meds (per pharmacist).	☐
*NOTE: If inhaler is a steroid, have resident rinse their mouth afterwards. *Give short-acting inhalers first (Ventolin, Combivent, Xopenex, Max-air) *Give long-acting inhaler second (Spiriva, HandiHaler) *Give Corticosteroids last (Symbicort, Pulmicort, AeroBid, Advair, Asmanex, Azmacort)		
11.	Remove gloves and wash hands.	☐
12.	Chart administration of medications.	☐

Comments: _____

08/12/2010
BMReed

MEDICATION PERFORMANCE CHECKLIST FOR SELECTED MEDICATIONS & TECHNIQUES

Name:		
	G-tube Medication or Bolus Feedings	**Checkoff**
1.	Get medication out of the cart; check 10 rights x 3.	☐
2.	Wash hands and prepare medications either by crushing or measuring liquids. Also prepare water for flushing.	☐
3.	Identify resident and yourself and explain procedure.	☐
4.	Place resident in Fowler's or semi-Fowler's position.	☐
5.	Place feeding pump on HOLD (if it is continuous feeding).	☐
6.	Check tube placement by insufflating 20cc of air through the port using a 60cc syringe. Listen with a stethoscope, of the epigastric region of the abdomen, for the whooshing sound, or aspirate gastric contents with a 30cc syringe. *If residual gastric contents measure 90cc or greater, notify the physician and possibly withhold the feeding per MD order.	☐
7.	Use the barrel of a 60cc syringe to flush tube with 60cc of water or whatever amount specified by physician order, using gravity flow or by gently pushing using the plunger of the syringe. *Always use tepid or warm water – never COLD as this can cause cramping.	☐
8.	Follow with medication either in liquid form or crushed finely and mixed in liquid.	☐
9.	Follow with at least 60cc water or whatever amount specified by physician order and turn pump back on. *Always leave head of the bed in the Fowler's or semi-Fowler's position.	☐
10.	Remove gloves and wash hands.	☐
11.	Chart administration of medication.	☐

Comments: _____

Name:	
Medications to be given at unusual times	
List:	
Check to see if medications are given at unusual times as ordered, i.e., 07:30, 12:30, 01:00, with meals, etc.	☐

Comments: _____

_____ Signature _____ Date

_____ RN's signature _____ Date

05/12/2010
BMReed

Glasgow State Nursing Facility	Department: Nursing	Total pages: 2
	Effective date: 05/11/2010	
References:	Policy Section: MEDICATIONS	
	Policy Name: one PACK™ PACKAGING	
	Facility: ☐	Departmental ☒

POLICY: The PACMED packaging system is a multiple dose system implemented by our contract pharmacy, Towne and Country Drugs.

PURPOSE: To safely dispense medications to each resident.

DESCRIPTION: The medications are packaged in a cellophane container with a maximum of three tablets per bag.

- A weekly supply of medications will be delivered for each resident and will be automatically refilled and sent from the pharmacy.
- Packaging will contain the resident's name, room number and bed, date and time to be administered, name and strength of the medication, identifiable markings of the medications along with the lot and expiration date of the medication.
- The Atromick Unit Dose System will continue to be used for PRN liquid medications, injectables, narcotics and those tablets too large to be placed in the PACMED system.
- Communication with the pharmacist must continue regularly, and the pharmacist must be kept informed of new residents, discharges, and any changes in the resident's medications.
- Physician's orders, labels, etc. for the PACMED system are to be faxed to The Prescription Center at 270-651-8873.
- Medications will be delivered to the facility the afternoon prior to the day the medications are to be administered to the resident.
- Upon delivery, the medications must be checked for accuracy against the current MAR, and the pharmacy must be notified immediately of any discrepancies.
- Each package must be reconciled against the resident's MAR as administered. **All medications must be administered according to the MAR**.
- If a pill in the PACMED system is dropped, the next pill in the package should be used. Tape the pill package back and contact the pharmacy by phone (270-651-8889) and fax (270-651-8873) to receive a replacement for the pill that was used when the other pill was dropped.
- After the contents of the bag have been used, the name of the resident on the bag should be removed and cut to prevent a violation of HIPAA.

- Any medication that has been discontinued between delivery dates should be identified and discarded into the sharps container.
- New orders (for the resident) will be sent out with the number of doses sent to coincide with the automatic delivery date for that unit. Future doses will be coordinated into the automated PACMED system.
- A conversion book, along with pill crushers, for medications (generic/brand names) will be located on each med cart.
- All other forms of medications (liquids, injectables, etc.) will continue to be reordered by FAX.
- Packaged medication that has not been opened may be returned to the pharmacy for appropriate credit.

This policy shall be reviewed annually and revised as necessary.

Approved by:

Phillip Bale, MD, Medical Director

Approved by:

Robert Oliver, RPh

Authorized by:_____ Date:_____
Facility Director

Glasgow State Nursing Facility	Department: Nursing	Total pages: 6
	Effective date: 04/26/2010	
References: Mosby's Textbook for Long-Term Care 5th edition	Policy Section: RESIDENT DAILY CARE Policy Name: Perineal Care	
	Facility ☐	Departmental ☒

Purpose: To facilitate cleanliness and comfort, to prevent skin breakdown, and to maintain the maximum amount of dignity.

PERINEAL CARE FOR FEMALE RESIDENTS

Quality of life:

- Knock before entering the resident's room.
- Address the resident by name.
- Introduce yourself by name and title.
- Explain the procedure to the resident before beginning and during the procedure.
- Protect the resident's rights during the procedure.
- Handle the person gently during the procedure.

Pre-procedure:

1. Practice hand hygiene
2. Collect the following
   - Soap or other cleaning agent as directed
   - At least 4 washcloths
   - Bath towel
   - Blanket
   - Wash basin on clean linen cart (only clean washcloths to be taken in room and placed on towel barrier on table).
   - Waterproof pad
   - Gloves
3. Cover the table with clean towel. Arrange items on top of clean towel.
4. Identify the person.
5. Provide for privacy.
6. Raise the bed for body mechanics.

Procedure:

1. Fill the wash basin. Water temperature should be about 105° to 109° F (40.5° to 42.7° C).
2. Decontaminate your hands. Put on gloves.
3. Cover the resident with a blanket. Move top linens to the foot of the bed.
4. Position the resident on their back.
5. Drape the resident.
6. Help the resident flex their knees and spread their legs. Or help the resident spread their legs as much as possible with the knees straight.
7. Place a waterproof pad under the buttocks. Protect the resident and any linen from the wet or soiled incontinence products. Place soiled linen in linen cart or on pad at foot of the bed.
8. Fold the corner of the blanket between the resident's legs onto their abdomen.
9. Wet the washcloths.
10. Squeeze out excess water from the washcloth. Make a mitted washcloth. Apply soap.
11. Separate the labia. Clean downward from front to back with one stroke.
12. Repeat steps 11 and 12 until the area is clean. Use a clean part of the washcloth for each stroke. Use more than one washcloth if needed.
13. Rinse the perineum with a clean washcloth. Separate the labia. Stroke downward from front to back. Repeat as necessary. Use a clean part of the washcloth of each stroke. Use more than one washcloth if needed.
14. Pat the area dry with the towel. Dry from front to back.
15. Fold the blanket back between the resident's legs.
16. Help the resident lower her legs and turn onto her side away from you. Apply soap to a mitted washcloth.
17. Clean the rectal area. Clean from the vagina to the anus with one stroke.
18. Repeat steps 18 and 19 until the area is clean. Use a clean part of the washcloth for each stroke. Use more than one washcloth if needed.
19. Rinse the rectal area with a washcloth. Stroke from the vagina to the anus. Repeat as necessary. Use a clean part of the washcloth for each stroke. Use more than one washcloth if needed.
20. Pat the area dry with the towel. Dry from front to back.
21. Remove the waterproof pad. Remove any wet or soiled incontinence product and linen.
22. Remove and discard the gloves. Decontaminate your hands. Put on clean gloves.
23. Provide clean and dry linens and incontinence products as needed.

Post-procedure:

1. Cover the resident. Remove the blanket.
2. Provide for comfort.
3. Place the signal light within reach.
4. Lower the bed to its lowest position.
5. Empty and clean the wash basin on the clean linen cart. Wear gloves.
6. Return the basin and supplies to their proper place.
7. Wipe off the table.

8. Remove the gloves. Decontaminate your hands
9. Unscreen the resident.
10. Complete a safety check of the room.
11. Follow facility policy for dirty linen.
12. Decontaminate your hands.
13. Report and record your observations.

PERINEAL CARE FOR MALE RESIDENTS

Quality of life:

- Knock before entering the resident's room.
- Address the resident by name.
- Introduce yourself by name and title.
- Explain the procedure to the resident before beginning and during the procedure.
- Protect the resident's rights during the procedure.
- Handle the person gently during the procedure.

Pre-procedure:

1. Practice hand hygiene
2. Collect the following
   - Soap or other cleaning agent as directed
   - At least 4 washcloths
   - Bath towel
   - Blanket
   - Wash basin on clean linen cart (only washcloths to be taken in room)
   - Waterproof pad
   - Gloves
3. Cover the table with towel. Arrange items on top.
4. Identify the person.
5. Provide for privacy.
6. Raise the bed for body mechanics.

Procedure:

1. Fill the wash basin. Water temperature should be about 105° to 109° F (40.5° to 42.7° C). Decontaminate your hands. Put on gloves.
2. Cover the resident with a blanket. Move top linens to the foot of the bed.
3. Position the resident on their back.
4. Drape the resident.
5. Place the basin on the table.
6. Place a waterproof pad under the resident's buttocks. Protect the resident and dry linen from the wet or soiled incontinence products. (Place soiled linen in dirty linen cart or on pad at foot of the bed.)
7. Retract the foreskin if the resident is uncircumcised.
8. Grasp the penis.
9. Clean the tip using a circular motion. Start at the meatus of the urethra, and work outward. Repeat as needed. Use a clean part of the washcloth each time.

10. Return the foreskin to its natural position.
11. Clean the shaft of the penis. Use firm, downward strokes. Rinse the area.
12. Help the resident flex his knees and spread his legs. Or help him spread his legs as much as possible with his knees straight.
13. Clean the scrotum. Rinse well. Observe for redness and irritation of the skin folds.
14. Pay dry the penis and the scrotum. Use the towel.
15. Fold the blanket back between his legs.
16. Help him lower his legs and turn onto his side away from you.
17. Clean the rectal area. Rinse and dry well.
18. Remove any wet or soiled incontinence products or linens. Remove the waterproof pad.
19. Remove and discard the gloves. Decontaminate your hands. Put on clean gloves.
20. Provide clean and dry linens and incontinence products.

Post-procedure:
1. Cover the resident. Remove the blanket.
2. Provide for comfort.
3. Place the signal light within reach.
4. Lower the bed to its lowest position.
5. Empty and clean the wash basin from the clean linen cart. Wear gloves.
6. Return the basin and supplies to their proper place.
7. Remove the gloves. Decontaminate your hands.
8. Unscreen the resident.
9. Complete a safety check of the room.
10. Follow facility policy for dirty linen.
11. Decontaminate your hands.
12. Report and record your observations.

This policy shall be reviewed annually and revised as necessary.

Authorized by:_____ Date:_____
Facility Director

PERINEAL CARE FOR THE FEMALE RESIDENT

	Steps	Checkoff
1.	Fill the wash basin with warm water.	☐
2.	Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands (hand sanitizer). Provide for privacy.	☐
3.	Raise bed to the best level for good body mechanics.	☐
4.	Position the resident on her back, drape with a blanket and remove top linen.	☐
5.	Put on disposable gloves.	☐
6.	Place a waterproof pad under buttocks.	☐
7.	Assist the resident to flex knees and spread legs, if able. Otherwise, help the resident to spread legs as much as possible with knees straight.	☐
8.	Apply soap on a washcloth.	☐
9.	Separate the labia. Clean downward from front to back with one stroke.*	☐
10.	Repeat steps 7 and 8 until the area is clean. Use a clean part of the washcloth for each stroke. Use more than one washcloth if needed.	☐
11.	Rinse the perineum with a washcloth. Separate the labia. Stroke downward from front to back.*	☐
12.	Pat the area dry with a towel.	☐
13.	Assist the resident to lower the legs and turn onto the side away from you.	☐
14.	Wash from the vagina to the anus with one stroke. Rinse and pat dry.*	☐
15.	Remove waterproof pad.	☐
16.	Remove and discard gloves.*	☐
17.	Cover the resident with top linen and remove the blanket.	☐
18.	Lower bed. Attach signal light, if indicated, within resident's reach.	☐
19.	Wash hands (hand sanitizer) and report and record observations.	☐

***Denotes critical step**

_____ _____
Signature Date

_____ _____
Staff Development Instructor's signature Date

PERINEAL CARE FOR THE MALE RESIDENT

	Steps	Checkoff
1.	Fill the wash basin with warm water.	☐
2.	Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands (hand sanitizer). Provide for privacy.	☐
3.	Raise bed to the best level for good body mechanics.	☐
4.	Position the resident on his back, drape with a blanket and remove top linen.	☐
5.	Put on disposable gloves.	☐
6.	Place a waterproof pad under buttocks.	☐
7.	Retract the foreskin if the person is uncircumcised.	☐
8.	Grasp the penis.	☐
9.	Clean the tip. Use a circular motion. Start at the urethra and work outward. Repeat as needed. Use a clean part of the washcloth each time.	☐
10.	Rinse the area with another washcloth.	☐
11.	Return the foreskin to its natural position.	☐
12.	Clean the shaft of the penis. Use firm downward strokes away from the urinary meatus. Rinse the area.	☐
13.	Help the resident flex his knees and spread his legs, or help him spread his legs as much as possible with knees straight.	☐
14.	Clean the scrotum. Rinse well. Observe for redness and irritation in the skin folds.	☐
15.	Pat the penis and scrotum dry.	☐
16.	Help him lower his legs, cover him, and turn him onto his side away from you. Fold the blanket back between his legs.	☐
17.	Wash, rinse, and pat dry the anal area. Wash from the scrotum to the anus with one stroke.	☐
18.	Remove the waterproof pad.	☐
19.	Remove and discard gloves.*	☐
20.	Cover the resident with top linen and remove blanket.	☐
21.	Lower bed. Attach signal light (if appropriate) within resident's reach.	☐
22.	Wash hands (hand sanitizer) and report and record observations.	☐

***Denotes critical step**

Signature _____ Date _____

Staff Development Instructor's signature _____ Date _____

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

PRINTED: 02/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185363	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW STATE NURSING FACILITY	199 STATE AVENUE P.O. BOX 189 GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted on 04/21/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) relating to NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

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

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