

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

PRINTED: 05/11/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/27/2012
NAME OF PROVIDER OR SUPPLIER  GLENVIEW HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. 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)

F 000 INITIAL COMMENTS

F 000

An annual recertification survey and an abbreviated survey (KY #18212) was conducted on 04/24/12 through 04/27/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E." KY #18212 was substantiated with deficiencies cited.

The submission of this plan of correction does not constitute an admission of guilt by the facility of the cited deficiencies or any violation of a regulation or a standard of care. Also, we reserve the right to take further action, including any and all legal means necessary, to resolve any dispute about the accuracy of this information

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)  
SS-D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

F 225 483.13(c)(1)(ii)-(iii), (c)(2)-(4)

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

1. Facility was unaware of the alleged incident reported by resident #9 at the time the alleged incident occurred on 11/09/2011. Facility was made aware of the alleged incident by Adult Protective Services (APS) when they entered the facility on 12/21/2011. Administrative staff began an immediate investigation. The completed investigations by both the facility and Adult Protective Services found the complaint unsubstantiated.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)

2. The facility will initiate an immediate investigation into any report of alleged abuse according to the facility's "Resident Abuse, Neglect, Mistreatment, Exploitation and Misappropriation of Property" policy.

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

3. The facility will report all allegations of abuse to the appropriate agencies as required in accordance with state and federal regulations. (continued on page 2)

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

*Yvonne D. Cook*

TITLE

Administrator

(X6) DATE

5/24/2012

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 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</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 report an allegation of sexual abuse to the State Agency, which was investigated by the Adult Protective Services (APS), for one resident (#9), in the selected sample of fourteen residents. Additionally, the facility failed to ensure a thorough investigation was completed related to an elopement incident for one resident (#15), not in the selected sample.</p> <p>Findings include:</p> <p>1. A review of the facility's policy/procedure for "Resident Abuse, Neglect, Mistreatment, Exploitation and Misappropriation of Property," dated September 2004, revealed incidents shall be thoroughly investigated and documented by the Administrator, Director of Nursing (DON), or designee and reported to the appropriate State Agencies.</p> <p>A record review revealed the facility admitted Resident #9 on 11/08/11 with diagnoses to</p>	F 225	<p>(continued from page 1)</p> <p>4. If the allegations are verified, appropriate corrective action will be initiated.</p> <p>5. Any reported incident of abuse will be reported to the Administrator and Director of Nursing immediately. Corrective actions will occur to ensure the safety of all individuals involved.</p> <p>6. Within 5 working days, the facility will report its findings to the appropriate agencies.</p> <p>7. All alleged incidents of abuse will be reported by the Administrator to the QA committee for review monthly for a period of 12 months.</p> <p>8. Concerning resident #15 no elopement occurred per definition. "Elopement" means an occurrence in which a resident leaves a facility without following facility policies and procedures (see attachment A). Resident #15 was not a missing resident according to the facility's "Missing Resident Policy" (see attachment C) due to the fact that her location was known at all times.</p> <p>(see attachment B) (continued on page 3)</p>

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F 225	<p>Continued From page 2</p> <p>include Senile Dementia, Depression, and Diabetes.</p> <p>On 04/24/12, during an initial tour of the facility, Resident #9 reported to the surveyor, that on 11/09/11, Resident #7 placed his/her hand on Resident #9's knee and then slid his/her hand up to his/her "private area." Resident #9 revealed he/she reported the alleged incident to the staff on 11/09/11. Adult Protection Services (APS) investigated this alleged incident on 12/21/11, and the facility investigated the alleged incident on 12/22/11. Both APS and the facility found the allegation to be unsubstantiated; however, the facility failed to notify the State Agency about the allegation of sexual abuse.</p> <p>An interview with the DON, on 04/27/12 at 2:00 PM, revealed the facility did not follow reporting guidelines related to the abuse/neglect policy, when the facility did not report Resident #9's allegation of sexual abuse to the State Agency.</p> <p>An interview with the Administrator, on 04/27/12 at 2:05 PM, revealed the allegation of sexual abuse was not reported to the State Agency, even though APS entered the facility on 12/21/11 and investigated the allegation.</p> <p>An interview with the Facility's Owner, on 04/27/12 at 2:05 PM, revealed Resident #9's allegation of sexual abuse was not reported to the State Agency. No further explanation was provided.</p> <p>2. A review of the facility's policy/procedure, "Wander Alert Policy," revised 07/06/11, revealed the wander alert bracelet system will be used for</p>	F 225	<p>(continued from page 2)</p> <p>9. A behavior was observed by (3) nurses at the nurses station and a housekeeper in the hall in which resident #15 went to the front door which is by the nurses station, and was looking for "her dog". She was never out of sight of employees and her location was being monitored. Resident #15 never let go of the door handle to the front door.</p> <p>10. Resident #15 was quickly redirected by the staff due to all staff being aware she was identified as a risk for wandering.</p> <p>11. Care plan for resident #15 was updated to encourage walks outside with activity personnel as weather allows.</p> <p>12. Other residents at risk for wandering have been identified through obtaining resident history upon admission. Nursing staff assess for exhibition of wandering behavior every shift and as needed.</p> <p>13. Quarterly assessment for exhibition of wandering behavior is performed through the MDS process. Residents identified at risk for behavior are care planned and interventions put into place.</p> <p>(continued on page 4)</p>

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F 225	Continued From page 3  safety of residents with behaviors of wandering placing them at risk for elopement. Resident history will be obtained on admission for history of wandering. Resident behavior will be monitored for signs of wandering or risk of elopement. Wander alert will be used only on those residents identified with history or behavior of wandering placing them at risk for elopement. A master listing of residents with wander alert will be maintained at the nursing station. Wander alert will be monitored for placement and proper functioning daily and documented on the Daily Reading Report. Wander alert will be monitored for placement and proper functioning every shift and documented on the Treatment Administration Record (TAR).  A record review revealed the facility admitted Resident #15 on 12/16/11 with diagnoses to include Senile Dementia, Anemia, and Hip Joint Replacement. A review of the the admission MDS, dated 12/29/11, and a review of the quarterly Minimum Data Set, (MDS), dated 03/15/12, revealed the resident had a Brief Interview for Mental Status (BIMS) score of "5." The resident was assessed as severely cognitively impaired and never/rarely made decisions. The facility placed a code alert bracelet on the resident's wrist on 12/16/11 and initiated every 15 minute safety checks.  A review of the comprehensive care plan "Alteration in mood and behavior AED: wandering, history of taking off wanderguard, easily annoyed, aggravating others, horseplaying, inappropriate voiding in trash can," dated 02/07/12, revealed interventions of safety checks as ordered and a wanderguard for safety.	F 225	(continued from page 3)  14. Wanderalerts are utilized for residents who are identified at risk for wandering behavior as per facility "Wanderalert Policy". There is a master list of residents with wanderalerts at the nurses station which is updated by the RN on duty with follow-ups as needed.  15. Residents with wanderalerts are placed on every 15 minutes safety checks where nursing staff monitor location and ensure wanderalert is in place per facility "Safety Check Policy" (see attachment E).  16. The Maintenance Director checks wanderalert system monthly to ensure system is functioning correctly.  17. The Maintenance Director gives the maintenance report to the Administrator monthly. The Administrator presents the report to the QA committee monthly for 12 months.  18. Resident behaviors will be documented and the Director of Nursing and the Administrator notified concerning behavior report. Resident behaviors will be reviewed by Resident Services Director. The Resident Services Director will submit monthly report to the Administrator. (continued on page 5)		

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F 225	Continued From page 4  On 03/15/12, the facility assessed the resident as displaying wandering behavior one to three days during the review period. A review of the Certified Nurse Aide (CNA) care guide revealed the resident was identified as a wander alert and was on safety checks every 15 minutes.  Observation, on 04/25/12 at 1:45 PM, revealed Resident #15 walked out the front door of the facility and a male staff walked the resident back into the facility. There was no alarm sounding when the resident exited the building, and no alarm sounded when the male staff assisted the resident back into the facility.  An interview with Licensed Practical Nurse (LPN) #1, on 04/26/12 at 1:05 PM and 2:00 PM, revealed Resident #15 went out the front door after a physician exited the building. She stated Resident #15 caught the door when the physician exited the building, and he/she was on the front porch talking about a dog he/she saw over at the bank. LPN #1 was at the desk when she noticed the housekeeper bringing the resident back into the building. The resident had a code alert bracelet (wander guard) in place and she could not recall if an alarm sounded when the resident exited the building. After being brought back into the facility, Resident #15 was assisted into the dining room area and a new code alert (wander guard) was applied. She reported to the DON, the family and the physician; however, she not document anything related to the incident, on 04/25/12, because she did not see anything. She revealed she looked up and saw the housekeeper bring the resident back into the building and he stated that Resident #15 went out the door after	F 225	(continued from page 4)  19. The Administrator will submit the report to the QA committee for review monthly for 12 months.	05/31/2012	

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F 225 Continued From page 5

F 225

the physician. Upon admission to the facility, the resident was determined to be a wander risk, and the code alert was applied at the time. She revealed when Resident #15 went out the front door and the staff brought the resident back in, it was considered an elopement.

An interview with the Housekeeper, on 04/26/12 at 2:15 PM, revealed he observed the resident walk out the door. Resident #15 was on the front porch, holding the door open and he/she stated he/she wanted to get his/her dog. He saw LPN #1 at the desk along with two other people and he did not recall hearing an alarm sound. Normally if residents walked by the doors with a code alert in place, it went off. If they sat on the couch, the alarm went off.

An interview with two CNAs, on 04/27/12 at 9:40 AM and 10:00 AM, revealed they were familiar with Resident #15 and they were aware he/she wandered in the facility. They stated the resident went to the doors but they had not observed the resident go out the doors. The CNAs stated the resident had a code alert bracelet in place and he/she was on every 15 minute safety checks. They stated the resident was fairly easy to redirect when he/she was by the exit doors.

An interview with the DON, on 04/27/12 at 4:25 PM, revealed, upon admission, they get a history on the residents. A wander alert bracelet was placed on the resident who was identified as a wanderer and 15 minute safety checks were started. The nurses also had a place on the TARs to document the code alert bracelets being in place and working. When Resident #15 was admitted to the facility, the resident's family

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F 225	<p>Continued From page 6</p> <p>informed the facility about his/her history of wandering. Resident #15 was placed on 15 minute safety checks and a code alert bracelet was applied to the resident's wrist. Resident #15 was monitored by the staff with the 15 minute checks. She was told the housekeeper came up the hall and the resident was in his site the whole time. The resident caught the door as the physician was leaving the building. They did not hear an alarm sounding because he/she took the code alert bracelet off. Resident #15 continued on the 15 minute checks and the staff were instructed to do an "extra glance" to ensure the code alert bracelet was in place.</p> <p>The facility was unable to provide evidence of an investigation regarding Resident #15's elopement on 04/25/12. The facility provided two post-behavior care plans, dated 04/26/12, related to the wandering behavior and removing the wander guard. There was no evidence of interviews with the staff or the residents who witnessed Resident #15 exiting the building.</p> <p>An interview with the facility's owner, on 04/27/12 at 5:28 PM, revealed an alarm did not sound related to the incident involving Resident #15. She stated the resident removed the code alert bracelet and the staff was in communication with the nurse. The resident remained on 15 minute checks and the staff were directed not to do anything different. She stated there was no investigation because she did not feel it was an elopement. She stated the resident had his/her hand on the front door and the staff had the resident in their sight.</p>	F 225		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS	F 281	483.20(k)(3)(i) (continued on page 8)	

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F 281	Continued From page 7  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one resident (#16), not in the selected sample. On 04/24/12 at 11:32 AM, during a medication pass, Certified Medication Technician (CMT) #1 failed to administer the resident's medication in accordance with the physician's orders.  Findings include:  A review of the facility's policy/procedure, "Medication, Administration of Oral," undated, revealed routine medications should be administered within 60 minutes before or after the scheduled medication pass time as directed per facility policy.  A review of the Medication Administration Record (MAR), dated April 2012, revealed Flexaril 10 mg tab at 9:00 AM and the following medications due at 10:00 AM: Bisoprolol 5 mg tab, Digoxin .125 mg tab (3) tablets, Diltiazem HCL 60 mg tab, Potassium Chloride 10 milliequivalents (1) capsule, Colace 150 mg/15 milliliters (ml), and Lactulose solution 10 grams (gm)/15 ml -30 ml.  An observation during the medication pass, on 04/24/12 at 11:32 AM, revealed CMT #1 offered	F 281	(continued from page 7)  1. On 04-22-2012 at 11:32am, CMT #1 failed to administer the resident's medications in accordance with MD orders. CMT #1 followed facility policy "Medicine Administration Out of Time Compliance" (see attachment F) on 04/22/2012 by notifying LPN #2 and the ARNP who was at the facility at the time (ARNP is nurse practitioner from primary physician's office). Resident #16 did refuse all medications during the medication administration pass despite multiple attempts from multiple staff and the ARNP.  2. No medications were administered to resident #16 because of resident refusal to take medications.  3. ARNP completed a progress note dated 04/24/2012 in which she noted medications that were late and attempts to administer the medications, including her attempts to give resident #16 her prescribed medications. ARNP noted resident #16's refusal and and "try meds in am" at next scheduled administration time.  (continued on page 9)		

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F 281	<p>Continued From page 8</p> <p>Resident #16 Bisoprolol 5 milligrams (mg) tablet, Digoxin .125 mg (3) tablets, Diltazepam HCL 60 mg (1) tablet, Flexaril 10 mg (1) tablet, Potassium Chloride 10 milliequivalents (1) capsule, Colace 150 mg/15 milliliters (ml), and Lactulose solution 10 grams (gm)/15 ml -30 ml. Resident #16 refused all medications and CMT #1 tried to encourage the resident to take his/her medications, but he/she continued to refuse.</p> <p>An interview with CMT #1, on 04/24/12 at 2:10 PM, revealed she had one hour before or one hour after the scheduled time to administer the medications. She revealed there were a couple of difficult residents during the medication pass and she was "running behind." She was aware she was out of compliance during administration of the residents' medications. They were expected to inform the nurse if she was unable to administer the medications timely. She stated she informed Licensed Practical Nurse (LPN) #2 about not being able to administer Resident #16's medications as ordered.</p> <p>An interview with LPN #2, on 04/27/12 at 2:25 PM, revealed she was informed by CMT #1 that she was unable to administer Resident #16's medications in a timely manner. The Advance Practice Registered Nurse (APRN) was in the facility and aware they were out of compliance, and was also aware the resident refused his/her medications. The CMTs usually informed the nurses aware whenever they were late with administration of medications. They were expected to administer the resident's medication as ordered by the physician, and at the correct time.</p>	F 281	<p>(continued from page 8)</p> <p>4. No other resident medications were administered out of time compliance on this specific medication administration pass.</p> <p>5. Staff Development Nurse and the Nurse Consultant from the pharmacy completed a Medication Administration Time Compliance inservice with all nurses and cmts on 05/15/2012 regarding the facility's policy and procedures of "Medication Administration Outside of Time Compliance".</p> <p>6. The Director of nursing will track any reports of medications given out of time compliance. A monthly report will be given to the Administrator.</p> <p>7. The Administrator will submit the monthly report to the QA committee on a monthly basis for review for 12 months. 05/31/2012</p>

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F 281	Continued From page 9 An interview with the Director of Nursing (DON), on 04/27/12 at 4:25 PM, revealed CMT #1 was out of compliance with administration of the medications and the staff were expected to administer medications as ordered. The CMTs should let the nurses know if they were running behind, so the physician could be notified.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for one resident (#1), in the selected sample of fourteen residents. Resident #1 was transferred from the wheelchair to the shower chair with the assistance of two staff members; however, the care plan indicated the resident required the assistance of three staff members for transfers.  Findings include:  A review of the facility's "Care Plan" policy/procedure, undated, revealed a resident's needs would be provided for by a developed plan of care.  A record review revealed the facility admitted	F 282	483.20(k)(3)(ii)  1. Resident #1 was transferred from wheelchair to shower chair with assist of 2. Care plan indicated assist of 3 for transfers.  2. Resident #1 was care planned for assist of 3 for transfers. On 04/24/2012 at 3:20pm (time of observation) 3 staff members were available for the transfer yet surveyor asked one staff member (LPN) to wait outside of shower room due to "space limitations".  3. Resident #1's transfer assessment was reassessed with care plan revision on 05/16/2012.  4. All residents plan of care regarding transfer assistance were reviewed by Asst Director of Nursing and CNAs on 05/16/2012 with care plan revisions as necessary.	
			(continued on page 11)	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/27/2012
NAME OF PROVIDER OR SUPPLIER  GLENVIEW HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. 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)
F 282	<p>Continued From page 10</p> <p>Resident #1 on 05/23/11, with a re-admission date of 02/28/12, with diagnoses to include Distal Radius Fracture, Intertrochanteric Fracture, and Osteoarthritis.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/19/12, revealed the facility identified the resident as moderately cognitively impaired and required extensive assistance with transfers.</p> <p>A review of the Risk for Falls Care Plan, dated 06/04/11, revealed the facility identified the resident required an assistance of three staff for transfers, ambulation, and toileting. A review of the Fall Risk Assessment, dated 03/26/12, revealed the resident was at high risk for falls. A review of the Assignment Sheet, undated, revealed the resident required the assistance of three staff.</p> <p>An observation, on 04/25/12 at 3:20 PM, revealed Certified Nurse Aide (CNA) #4 and CNA #5 transferred Resident #1 from the wheelchair to the shower chair.</p> <p>A phone interview with CNA #4, on 04/27/12 at 2:40 PM, revealed she transferred Resident #1 from the wheelchair to the shower chair with the assistance of CNA #5. She was not aware the resident was care planned for the assistance of three staff.</p> <p>A phone interview with CNA #5, on 04/27/12 at 3:00 PM, revealed she was aware the resident required assistance of three staff for transfers; however, there was not enough staff available at the time. She revealed she was suppose to follow</p>	F 282	<p>(continued from page 10)</p> <p>5. On 05/31/2012 the Staff Development Nurse / Director of Nursing will inservice all nursing staff regarding the importance of following the plan of care for each resident.</p> <p>6. Included in the above inservice will be training on notifying the nurse or the Director / Asst. Director of Nursing regarding any resident change in status.</p> <p>7. The resident care plans will be updated by the nurse as needed. The MDS nurse will review any change in status during the MDS process with the care plan team.</p> <p>8. The Asst. Director of Nursing will review all updates weekly and report to the Director of Nursing.</p> <p>9. The Director of Nursing will submit the report to the Administrator monthly. The Administrator will submit the report to the QA committee monthly for review for 12 months. 05/31/2012</p>

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F 282	Continued From page 11 the assignment sheet.  An interview with the Director of Nursing (DON), on 04/27/12 at 4:05 PM, revealed Resident #1 required assistance of three staff (or the mechanical lift) for transfers. She revealed staff were expected to follow the assignment sheets. Staff should also report any changes so the resident could be reassessed.	F 282			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	483.25(h)		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies/procedures, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for three residents (#1, #4, and #13), in the selected sample of fourteen residents. Resident #13 wandered into a resident's room and climbed into the bed with Resident #4. There was no staff supervision on the unit and Resident #13's bed alarm did not sound. Additionally, staff were observed to transfer Resident #1 with the assistance of two staff members; however, the facility had assessed the resident to require the		1. Bed alarm was utilized on resident #13 due to history of wandering. Per facility policy and procedure "Wheelchair / Bed Alarms" the bed alarms are monitored for placement and checked for functioning every shift and documented by nurse on treatment record. Resident #13's alarm was checked earlier in the shift and was working properly. Safety checks were utilized every 15 minutes according to facility policy and procedures and were performed correctly. Due to staff diligence of making rounds and performing safety checks, resident #13 was found quickly before further incident. Resident #13 was removed from the room and resident #4 was immediately assessed by nurse. (continued on page 13)		

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F 323	<p>Continued From page 12</p> <p>assistance of three staff members with transfers.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure for "Safety Checks," dated 10/23/06, revealed the facility would offer extra assessment opportunities for special resident situations. These assessment opportunities would promote and maintain resident safety.</p> <p>1. A record review revealed the facility admitted Resident #13 on 02/08/12, with a re-admission date of 04/11/12. The resident's diagnoses included Alzheimer's Disease, Insomnia, Dementia, Anxiety, and Depression.</p> <p>A review of the admission Minimum Data Set (MDS), dated 02/20/12, revealed the facility identified the resident as severely cognitively impaired with behaviors to include wandering.</p> <p>A review of the care plan for "Alteration in Mood and Behavior," dated 02/17/12, revealed the facility identified that Resident #13 exhibited the following behaviors: disrobing during the night and trying to pull the staff into the bed with him/her, sexual comments, combative behavior, wandering, sexual aggression toward staff, and frequent masturbation. Further review of the care plan revealed staff were to check the resident every fifteen minutes and when passing the resident's room, for needs and safety. A review of the care plan for "Falls," dated 02/24/12, revealed the resident had a bed alarm for safety. Staff were to check the placement and functioning of the alarm every shift and as needed.</p>	F 323	<p>(continued from page 12)</p> <p>CNA #3 was on the unit at the time of occurrence. Kiosk in front dining room is considered to be part of the building designated as Long Hall. The nursing home has 2 halls, Long Hall and Short Hall, with one nurses station for both units.</p> <p>Resident #13 was immediately placed under 1:1 constant supervision until he was discharged from the facility on 04/20/2012.</p> <p>Resident #4 was transferred to the local ER for evaluation. Resident #4 was shortly returned to facility after medical personnel deemed no injury had occurred.</p> <p>Local authorities, Adult Protective Services and state agencies were contacted on 02/20/2012 regarding the incident. Investigations were completed by the facility, local authorities and Adult Protective Services and it was determined that the facility acted appropriately and that no injury had occurred to resident #4. A completed report of the facility investigation was sent to the appropriate state agency.</p> <p>2. The Staff Development Nurse inserviced the nursing staff on 04/20/2012 on the facility's abuse policy and procedures.</p> <p>(continued on page 14)</p>	

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F 323	<p>Continued From page 13</p> <p>2. A record review revealed the facility admitted Resident #4 on 08/26/11 with diagnoses to include Alzheimer's Disease and Dementia.</p> <p>A review of the quarterly MDS, dated 02/21/12, revealed the facility identified the resident as severely cognitively impaired and required total assistance with bed mobility. The resident was non-ambulatory.</p> <p>A review of the nurse's notes, dated 04/20/12 at 3:25 AM, revealed Resident #13 was found in the bed with Resident #4. Further review revealed Resident #13 was "on all fours" hovering over Resident #4.</p> <p>A review of the facility's investigation, dated 04/27/12, revealed staff documented a safety check on Resident #13, on 04/20/12 at 3:00 AM, noting the resident was asleep. According to the investigation, Resident #13 exited his/her room at approximately 3:12 AM and entered Resident #4's room. The bed alarm for Resident #13 did not sound. Staff was not on the unit at this time. At approximately 3:21 AM, staff found Resident #13 in Resident #4's bed, on top of him/her.</p> <p>A phone interview with Certified Nurse Aide (CNA) #3, on 04/26/12 at 3:30 PM, revealed she was the aide working on 04/20/12. She revealed prior to the incident with Resident #13 and Resident #4, Resident #13 had been in his/her bed asleep. She revealed Resident #13 was checked 15-20 minutes prior to finding him/her in the bed with Resident #4. CNA #3 admitted Resident #13's bed alarm did not sound, and she was not on the unit at the time of the incident. She stated that she was charting on the kiosk in</p>	F 323	<p>(continued from page 13)</p> <p>3. The Staff Development Nurse inserviced the facility staff on 04/23/2012 on the facility's abuse policy and procedures.</p> <p>4. As per facility guidelines a staff member is to be present on each hall at all times. The facility did update the documentation guideline in accordance to kiosk charting. The staff member assigned to remain on the hall will document any resident care provided on the kiosk in the middle of each hall. Inservice completed on 04/20/2012.</p> <p>5. Resident #1 was transferred from wheelchair to shower chair with assist of 2. Care plan indicated assist of 3 for transfers.</p> <p>(continued on page 15)</p>

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F 323	<p>Continued From page 14</p> <p>the dining room; however, she stated she should have been charting on the kiosk located on the unit.</p> <p>A phone interview with Licensed Practical Nurse (LPN) #3, on 04/27/12 at 9:30 AM, revealed she was the nurse working on 04/20/12. She revealed a staff member was suppose to be on the unit at all times, but CNA #3 was charting on the kiosk in the dining room, not on the unit. She further revealed Resident #13's bed alarm sounded earlier in the shift; however, it did not sound prior to finding him/her in the bed with Resident #4. She revealed the alarm was "wrinkled" in the bed causing it not to function properly.</p> <p>An interview with the Director of Nursing (DON), on 04/27/12 at 4:05 PM, revealed the bed alarm did not function properly during the incident, on 04/20/12. She revealed CNA #3 was the only aide on the unit. She expected CNA #3 to use the kiosk on the hall, not the dining room.</p> <p>3. A record review revealed the facility admitted Resident #1 on 05/23/11, with a re-admission date of 02/28/12 with diagnoses to include Distal Radius Fracture, Intertrochanteric Fracture, and Osteoarthritis.</p> <p>A review of the quarterly MDS, dated 01/19/12, revealed the facility identified the resident as moderately cognitively impaired and required extensive assistance with transfers.</p> <p>A review of the Risk for Falls Care Plan, dated 06/04/11, revealed the facility identified the resident required the assistance of three staff members for transfers, ambulation, and toileting.</p>	F 323	<p>(continued from page 14)</p> <p>6. Resident #1 was care planned for assist of 3 for transfers. At 3:20pm on 04/25/2012 (time of observation) 3 staff members were available at shower room entrance for transfer. The surveyor asked the 3rd staff member (LPN) to wait outside of the shower room due to "space limitations". Resident #1's transfer assessment was reassessed with care plan revisions on 05/16/2012.</p> <p>7. On 05/16/2012 all resident plan of care regarding transfer assistance were reviewed by Asst. Director of Nursing and CNAs. Care plan revisions were completed as necessary.</p> <p>8. On 05/31/2012 the Staff Development Nurse / Director of Nursing will inservice the nursing staff on the importance on following the plan care and on notifying the nurse, Director/Asst. Director of Nursing of change in resident status.</p> <p>9. The care plan will be updated by the nurse as needed. The MDS nurse will review any changes made through the MDS process with the care plan team.</p> <p>10. The Asst. Director of Nursing will review the changes weekly and will report to the Director</p> <p>(continued on page 16)</p>

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NAME OF PROVIDER OR SUPPLIER  GLENVIEW HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141
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F 323 Continued From page 15

A review of the Fall Risk Assessment, dated 03/26/12, revealed the resident was at high risk for falls.

An observation, on 04/25/12 at 3:20 PM, revealed CNA #4 and CNA #5 transferred Resident #1 from the wheelchair to the shower chair.

A phone interview with CNA #4, on 04/27/12 at 2:40 PM, revealed she transferred Resident #1 from the wheelchair to the shower chair with CNA #5. She revealed the resident required 2-3 staff assistance for transfers. She was not aware the resident was care planned for assistance of three staff.

A phone interview with CNA #5, on 04/27/12 at 3:00 PM, revealed she was aware the resident required assistance of three staff for transfers; however, there was not enough staff available at the time.

An interview with the DON, on 04/27/12 at 4:05 PM, revealed Resident #1 required assistance of three staff (or the mechanical lift) for transfers. She revealed the staff were expected to follow the assignment sheets. Staff should also report any changes so the resident could be reassessed.

F 323 (continued from page 15)

of Nursing. The Director of Nursing will submit a report to the Administrator monthly.

11. The Administrator will submit the report monthly to the QA committee for review for 12 months.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED  04/24/2012
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NAME OF PROVIDER OR SUPPLIER  GLENVIEW HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)  
BUILDING: 01  
PLAN APPROVAL: 1961, 1971, 1986  
SURVEY UNDER: 2000 Existing  
FACILITY TYPE: SNF/NF  
TYPE OF STRUCTURE: One (1) story, Type V (111)  
SMOKE COMPARTMENTS: Five (5) smoke compartments  
FIRE ALARM: Complete fire alarm system with heat and smoke detectors  
SPRINKLER SYSTEM: Complete automatic dry sprinkler system.  
GENERATOR: Type II generator. Fuel source is diesel.

A standard Life Safety Code survey was conducted on 04/24/12. Glenview Health Care Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty (60) beds with a census of fifty five (55) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

K 000 The submission of this plan of correction does not constitute an admission by the facility of the cited deficiencies or any violation of a regulation or standard of care. Also, we reserve the right to take further action, including any and all legal means necessary, to resolve any disputes about the accuracy of this information.

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

*[Handwritten Signature]*

TITLE

*Administrator*

(X6) DATE

07/16/2012

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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(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

185271

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

04/24/2012

NAME OF PROVIDER OR SUPPLIER

GLENVIEW HEALTH CARE FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

1002 GLENVIEW DR.  
GLASGOW, KY 42141

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  
PREFIX  
TAG

PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)

(X5)  
COMPLETION  
DATE

K 000 Continued From page 1

K 000

Deficiencies were cited with the highest  
deficiency identified at "F" level.

K 018 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

Doors protecting corridor openings in other than  
required enclosures of vertical openings, exits, or  
hazardous areas are substantial doors, such as  
those constructed of 1 1/4 inch solid-bonded core  
wood, or capable of resisting fire for at least 20  
minutes. Doors in sprinklered buildings are only  
required to resist the passage of smoke. There is  
no impediment to the closing of the doors. Doors  
are provided with a means suitable for keeping  
the door closed. Dutch doors meeting 19.3.6.3.6  
are permitted. 19.3.6.3

- K 018 1. The Maintenance Director repaired gaps in  
corridor doors to rooms 3,6,10,19,20 and 21 to  
resist any passage of smoke.  
2. The Maintenance Director checked all corridor  
doors throughout the building to ensure there  
are no impediments to the closing of the doors  
to resist the passage of smoke.  
3. The Maintenance Director will check all doors  
monthly and document condition of doors and  
repair as needed.  
4. The Maintenance Director will submit report  
to the Administrator and the findings will be  
reported monthly in QA meeting for 12 months. 06/30/2012

Roller latches are prohibited by CMS regulations  
in all health care facilities.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was  
determined the facility failed to ensure there were  
no impediments to the closing of corridor doors to  
resist the passage of smoke, in accordance with  
NFPA standards. The deficiency had the  
potential to affect four (4) of five (5) smoke  
compartments, residents, staff, and visitors. The  
facility is licensed for sixty (60) beds and the

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K 018	<p>Continued From page 2</p> <p>census was fifty five (55) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 04/24/12 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed the corridor doors to rooms 3, 6, 10, 19, 20, and 21 had a gap too large around the jamb and would not resist the passage of smoke.</p> <p>Interviews, on 04/24/12 between 11:00 AM and 4:00 PM, with the Maintenance Director confirmed the observation of the doors having too large a gap that would not resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard 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</p>	K 018	

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IDENTIFICATION NUMBER:

185271

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01  
B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

04/24/2012

NAME OF PROVIDER OR SUPPLIER

GLENVIEW HEALTH CARE FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

1002 GLENVIEW DR.  
GLASGOW, KY 42141

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  
PREFIX  
TAG

PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)

(X5)  
COMPLETION  
DATE

K 018 Continued From page 3

similar  
auxiliary spaces that do not contain flammable or  
combustible materials.  
Exception No. 2: In smoke compartments  
protected throughout by an approved, supervised  
automatic sprinkler system in accordance with  
19.3.5.2, the door construction requirements of  
19.3.6.3.1 shall not be mandatory, but the doors  
shall be constructed to resist the passage of  
smoke.  
19.3.6.3.2\* Doors shall be provided with a means  
suitable for keeping the door closed that is  
acceptable to the authority having jurisdiction.  
The device used shall be capable of keeping  
the door fully closed if a force of 5 lbf (22 N) is  
applied 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

K 018

K 025 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=C

Smoke barriers are constructed to provide at  
least a one half hour fire resistance rating in  
accordance with 8.3. Smoke barriers may  
terminate at an atrium wall. Windows are  
protected by fire-rated glazing or by wired glass  
panels and steel frames. A minimum of two  
separate compartments are provided on each  
floor. Dampers are not required in duct  
penetrations of smoke barriers in fully ducted  
heating, ventilating, and air conditioning systems.  
19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

K 025 1. The Maintenance Director repaired the smoke  
partitions extending above the ceiling located  
in the short hall. Noted penetrations by pipes  
and wires were repaired with a material rated  
equal to the partition and will resist the  
passage of smoke. Completed 04/27/2012.  
Began tacking up wire on sprinkler pipes on  
05/01/2012. Completed by 05/30/2012.  
2. The Maintenance Director will check all smoke  
partitions to ensure the barriers will resist the  
passage of smoke between smoke  
compartments in accordance with NFPA  
standards.

This STANDARD is not met as evidenced by:  
Based on observations and interview, it was

(continued on page 5)

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NAME OF PROVIDER OR SUPPLIER  GLENVIEW HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141	
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K 025	<p>Continued From page 4</p> <p>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 two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) bed with a census of fifty five (55) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/24/12 at 12:20 PM, with the Maintenance Director revealed the smoke partitions extending above the ceiling located in the Short Hall were noted to have penetrations by pipes and wires. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 04/24/12 at 12:20 PM, with the Maintenance Director revealed they were not aware of the penetrations.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <p>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</p>	K 025 3.	<p>The Maintenance Director will check all smoke partitions monthly to ensure compliance and will report findings to the Administrator monthly and will be monitored by the QA committee monthly for 12 months.</p> <p>06/30/2012</p>

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K 025	Continued From page 5  2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure access doors in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff, and		K 027 1. The Maintenance Director repaired the cross-corridor doors located in the middle hall and at the dining room so that they seal and close all the way so that doors do not have gaps. Completed on 04/25/2012. 2. The Maintenance Director checked doors in smoke barriers to ensure that they are installed in accordance with NFPA standards. 3. The Maintenance Director installed a WB-FR standard fire rated access door in attic.  4. The Maintenance Director will check doors in smoke barriers to ensure that they are installed in accordance with NFPA standards. 06/30/2012

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K 027	<p>Continued From page 6</p> <p>visitors. The facility is licensed for sixty (60) beds with a census of fifty five (55) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/24/12 at 12:20 PM, with the Maintenance Director revealed one (1) unrated homemade smoke barrier access doors located in the smoke partitions above the ceiling in the attic area throughout the facility.</p> <p>Interview, on 04/24/12 at 12:20 PM, with the Maintenance Director revealed he was not aware the door in the attic must be rated for use.</p> <p>Observation, on 04/24/12 between 2:00 PM and 2:30 PM, with the Maintenance Director revealed the cross-corridor doors located in the Middle Hall, and at the Dining Room, do not seal, or close all the way when tested, leaving a gap larger than one half of an inch at the top.</p> <p>Interview, on 04/24/12 between 2:00 PM and 2:30 PM, with the Maintenance Director revealed they were unaware the doors did not close and seal properly.</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p>	K 027	

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K 027. Continued From page 7	<p>Reference: NFPA 101 (2000 Edition) Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.</p> <p>Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p>	K 027	
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 029	<ol style="list-style-type: none"> <li>1. The Maintenance Director will place door closure on the kitchen door from the dining by 06/30/2012.</li> <li>2. The Maintenance Director inspected the entire building to ensure that all doors requiring self closing devices has them as required by NFPA standards.</li> <li>3. The Maintenance Director will check all door closures monthly to ensure compliance with NFPA standards.</li> </ol>
This STANDARD is not met as evidenced by:		(continued on page 9)	

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K 029	<p>Continued From page 8</p> <p>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 five (5) smoke compartments, residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 04/24/12 at 1:56 PM, with the Maintenance Director revealed the door to the Kitchen from the Dining Room did not have a self closing device.</p> <p>Interview, on 04/24/12 at 1:56 PM, with the Maintenance Director revealed they were not aware the door was required to be self closing.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 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>	K 029 4.	<p>The Maintenance Director will report findings monthly to the Administrator and will be discussed in the monthly QA committee meeting for 12 months.</p> <p>06/30/2012</p>

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K 029	Continued From page 9 (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 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.	K 029	
K 039 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained, per NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty five (55) on the day of the survey.	K 039	1. The exit access signs in the back dining room will be removed. 2. The point of egress for the back dining room will be the front door access as allowed within NFPA guidelines.  3. Staff inservicing will occur to ensure all staff are trained on the updated egress policy and procedures. 4. Updated evacuation plans will be posted according to NFPA guidelines.  07/24/2012

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K 039	<p>Continued From page 10</p> <p>The findings include:</p> <p>Observation, on 04/24/12 at 2:10 PM, with the Maintenance Director revealed exit access to the public way from the dining room to be less than the minimum requirement in width. The exit access path between the two buildings narrows due to building placement, and two (2) air conditioning units projecting into the path.</p> <p>Interview, on 04/24/12 at 2:10 PM, revealed the facility did not realize exit access had a minimum width requirement.</p> <p>Reference: NFPA 101 (2000 edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 3 1/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below. 7.3.4 Minimum Width. 7.3.4.1 The width of any means of egress shall be not less than that required for a given egress component in Chapter 7 or Chapters 12 through 42, and shall be not less than 36 in. (91 cm). Exception No. 1*: The width of exit access formed by furniture and movable partitions, serving not more than six people and having a length not exceeding 50 ft (15 m), shall be not less than 18 in. (45.7 cm) at and below a height of 38 in. (96 cm), or 28 in. (71 cm) above a height of 38 in. (96 cm), provided that widths not less than 36 in. (91 cm) for new exit access and 28 in. (71 cm) for existing exit access are provided</p>	K 039	

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K 039	Continued From page 11 without moving permanent walls. Exception No. 2: This requirement shall not apply to doors as otherwise provided for in 7.2.1.2. Exception No. 3: In existing buildings, the width shall be permitted to be not less than 28 in. (71 cm). Exception No. 4: This requirement shall not apply to aisles and aisle accessways as otherwise provided in Chapters 12 and 13. Exception No. 5: This requirement shall not apply to industrial equipment access as otherwise provided in Chapter 40.	K 039	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on Fire Drill record review and interview, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds and the census was fifty five (55) on the day of the survey.	K 050 1.	1. Fire drills will be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. 2. Maintenance Director performed fire drills on 05/17/2012 and 05/24/2012 for missed fire drills in the quarters listed. 3. The Maintenance Director will check all fire drills performed to ensure fire drills were conducted quarterly on each shift at unexpected times.
			4. The Maintenance Director will perform fire drills quarterly on each shift at unexpected times. 5. The Maintenance Director will submit record of fire drills to the Administrator monthly and be monitored monthly by the QA committee for 12 months.  06/30/2012

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K 050	Continued From page 12  The findings include:  Fire Drill record review, on 04/24/12 at 11:48 AM, with the Maintenance Director revealed the fire drills were not being conducted quarterly and at unexpected times under varied conditions. The third shift fire drills were routinely being conducted between 5:15 AM and 5:45 AM. Further record review revealed the facility failed to perform a fire drill in the 3rd quarter of 2011, on first shift, and they also did not perform a fire drill in the 1st quarter of 2012 on first shift.  Interview, on 04/24/12 at 11:48 AM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required on third shift. Further interview revealed the facility did realize they had missed the fire drills in the quarters listed and performed one for each shift as soon as they realized they had been missed.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056	1. The facility's automatic sprinkler system will be modified to provide coverage over the front entrance and the Short Hall exit. 2. The Maintenance Director will inspect the system monthly to ensure compliance with NFPA standards. (continued on page 14)

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K 056 Continued From page 13  
Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

K 056 (continued from page 13)  
3. The Maintenance Director will monitor the sprinkler system monthly and report findings to Administrator, who will review findings with the QA committee monthly for 12 months. 07/20/2012

This STANDARD is not met as evidenced by:  
Based on observation and interview it was determined the facility failed to ensure the building had a complete automatic sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty five (55) on the day of the survey.

The findings include:

Observation, on 04/24/12 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed the facility had combustible porches that extended out four (4) foot or greater and were not sprinkler protected. The porches were located at the Front Entrance, and the Short Hall Exit. Further observation revealed a wooden trellis type roof also outside the Short Hall Exit, and it was not sprinkler protected.

Interview, on 04/24/12 between 11:00 AM and 4:00 AM, with the Maintenance Director revealed

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NAME OF PROVIDER OR SUPPLIER  GLENVIEW HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. 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)
K 056	<p>Continued From page 14</p> <p>they were not aware the porches or the trellis roof needed to be sprinkler protected.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <ol style="list-style-type: none"> <li>(1) Sprinklers installed throughout the premises</li> <li>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</li> <li>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</li> </ol>	K 056	

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K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty five (55) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 04/24/12 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed sprinkler heads of mixed response ratings were located in the attic over the Short Hall, the Janitors Closet in the front hall, and the front Dining Room.</p> <p>Interview, on 04/24/12 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed the facility was not aware of the mixed response sprinkler heads, and not sure why the sprinkler company contracted to maintain the sprinklers had not discovered the problem.</p>	K 062	<p>1. Maintenance Director worked with outside agency who specializes in sprinkler systems. Sprinkler heads of mixed response ratings in the attic over the short hall, the janitors closet in the front hall, the front dining room have been replaced. Completed 05/14/2012.</p> <p>2. Sprinkler company replaced the sprinkler head in the employee lounge bathroom. Completed 05/14/2012.</p> <p>3. Maintenance Director removed items in the oxygen room, and in the medical records storage room located in the basement. No items are within 18 inches of sprinkler heads. Completed 04/25/2012.</p> <p>4. The Maintenance Director will inspect all sprinkler heads in the building monthly to ensure compliance with NFPA standards.</p> <p>5. The Maintenance Director will check sprinkler heads monthly and report findings to the Administrator monthly who will discuss at the monthly QA committee for 12 months. 06/30/2012</p>

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K 062	<p>Continued From page 16</p> <p>Observation, on 04/24/12 at 2:19 PM, with the Maintenance Director revealed the sprinkler heads located in the employee lounge bathroom, to have paint on the heads decreasing their ability to react as intended.</p> <p>Interview, on 04/24/12 at 2:19 PM, with the Maintenance Director revealed they were not aware that the sprinklers heads had been painted.</p> <p>Observation, on 04/24/12 at 2:26 PM, with the Maintenance Director revealed storage within 18 inches of a sprinkler head located in the oxygen room, and in the Medical Records storage room located in the basement.</p> <p>Interview, on 04/24/12 at 2:26 PM, with the Maintenance Director revealed he was aware items could not be stored within 18 inches of a sprinkler head, but not sure who placed the items so close.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.</p> <p>2-2.1.1* Sprinklers shall be inspected from the</p>	K 062	

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K 062	Continued From page 17 floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066	1. The Maintenance Director removed improper ashtray located at resident smoking area and replaced it with approved ashtray.

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K 066	<p>Continued From page 18</p> <p>(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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(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</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 five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds and the census was fifty five (55) on the day of the survey.</p> <p>The findings include:  Observation, on 04/24/12 at 11:56 AM, with the</p>	K 066 2.	<p>The Maintenance Director will check smoking devices monthly to ensure they meet NFPA standards.</p> <p>3. The Maintenance Director will report findings to the Administrator and findings will be reviewed at the monthly QA committee for 12 months.</p> <p>06/30/2012</p>

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K 066 Continued From page 19  
Maintenance Director revealed the ashtrays located at the resident smoking area were not of the approved type. They did not have a metal container with a self-closing lid to dump ashtrays.  
  
Interview on 04/24/12 at 11:56 AM, with the Maintenance Director revealed he was not aware of the requirement for self-closing ashtrays.  
  
Reference: NFPA Standard 101 (2000 Edition).  
  
19.7.4 Smoking (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 076 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D  
Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  
  
(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  
  
(b) Locations for supply systems of greater than 3,000 cu ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4

K 076 1. The Maintenance Director placed signage on the outside door indicating liquid oxygen was being stored in the basement medical records room.  
  
2. The Maintenance Director checked all oxygen storage areas for signage indicating liquid oxygen was being stored.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was

(continued on page 21)

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K 076 Continued From page 20  
determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty five (55) on the day of the survey.

K 076 3. The Maintenance Director will check signage monthly and report findings to the Administrator and findings will be reviewed in the monthly QA meeting for 12 months. 06/30/2012

The findings include:

Observation, on 04/24/12 at 3:56 PM, with the Maintenance Director revealed there was no signage on the outside, indicating liquid oxygen was being stored in the basement Medical Records Room.

Interview, on 04/24/12 at 3:56 PM, with the Maintenance Director revealed they were not aware the oxygen tanks needed signage indicating they were in the room.

Reference: NFPA 99 (1999 edition)  
8-3.1.11.2

- Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3)
- (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.
  - (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.
  - (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:

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K 076	Continued From page 21  (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.  8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076	
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786	K 130	1. The Maintenance Director removed the slide bolt type lock on the employee lounge door on 04/25/2012.
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of the five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty five (55) on the day of the survey.		2. The Maintenance Director had conversation with Life Safety Code Inspector in which Life Safety Code Inspector commented that top of dryers were very clean, but bottom of dryers revealed a build-up of lint. Maintenance Director removed the build-up of lint from the lower portion of dryers on 04/24/2012.  (continued on page 23)

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K 130 Continued From page 22  
The findings include:

K 130

Observation, on 04/24/12 at 1:49 PM, with the Maintenance Director revealed an unapproved lock (slide bolt type) was installed on door to the Employee Lounge.

3. The Maintenance Director checked the entire building to ensure that unapproved locks were not being utilized in the building.

Interview, on 04/24/12 1:49 PM, with the Maintenance Director revealed he had never noticed the lock on the door, and would have it removed.

4. The Maintenance Director will check monthly for unapproved locks and report monthly to the Administrator. The findings will be monitored monthly in QA meeting for 12 months.

Observation, on 04/24/12 at 3:28 PM, with the Maintenance Director revealed a heavy build up of lint in the top of the dryer, in the Laundry Room.

5. The laundry staff will check lint build-up and log cleaning of areas every 2 hours.

Interview, on 04/24/12 at 3:28 PM, with the Maintenance Director revealed he was not aware the lint build up was so excessive.

6. The Hsk/Laundry supervisor will submit records monthly to the Administrator and will be reviewed in the monthly QA meeting for 12 months. 06/30/2012

Reference: NFPA 101 (2000 Edition)

19.2.2.2.4

Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.

K 143 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D

K 143

Transferring of oxygen is:

(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;

1. The Maintenance Director turned on the fan in the window of the medical records room in the basement and cleaned area of storage around the fan.

(b) in an area that is mechanically ventilated,

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K 143	<p>Continued From page 23</p> <p>sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to assure the room being used to transfer or store liquid oxygen had ventilation per NFPA requirements. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty five (55) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/24/12 at 3:56 PM, with the Maintenance Director revealed the Medical Records Storage Room in the basement, which oxygen was being transferred or stored did not have ventilation.</p> <p>Interview, on 04/24/12 at 3:56 PM, with the Maintenance Director revealed the tanks were delivered and picked up by a supply contractor from this room. Further interview at the exit</p>	K 143 2.	<p>The Maintenance Director will ensure mechanical fan is working daily and will report findings to the Administrator monthly</p> <p>3. Findings will be reviewed at the monthly QA meeting for 12 months.</p> <p>06/30/2012</p>

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K 143 Continued From page 24 K 143

conference revealed the room allegedly had a mechanical fan in the window but was not turned on. This could not be confirmed due to the abundance of storage in the room.

4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement).

(a) \* Nonflammable Gases (Any Quantity: In-Storage, Connected, or Both)

1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin.
2. \* Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose.
3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.
4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary

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locations. Electric wall fixtures, sw and re shall be installed in fixed locations not f 152 cm4 the floor as a precaution against their physical damage.

5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [ also 4-3.1.1.2(a) 7].

6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat.

7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage.  
Exception: Shipping crates or storage cartons for cylinders.

8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.

9. Containers shall not be stored in a tightly closed space such as a closet [ Copyright NFPA 99 8-2.1.2.3(c)].

10. Location of Supply Systems.  
a. Except as permitted by 4-3.1.1.2(a) 10c, supply systems for medical gases or mixtures of these gases having total capacities (connected and in storage) not exceeding the quantities specified in 4-3.1.1.2(b) 1 and 2 shall be located outdoors in an enclosure used only for this purpose or in a room or enclosure used only for this purpose situated within a building used for other purposes.  
b. Storage facilities that are outside, but adjacent to a building wall, shall be in accordance with

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NAME OF PROVIDER OR SUPPLIER  GLENVIEW HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. 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)
K 143	<p>Continued From page 26</p> <p>NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites.</p> <p>c. Locations for supply systems shall not be used for storage purposes other than for containers of nonflammable gases. Storage of full or empty containers shall be permitted. Other nonflammable medical gas supply systems or storage locations shall be permitted to be in the same location with oxygen or nitrous oxide or both. However, care shall be taken to provide adequate ventilation to dissipate such other gases in order to prevent the development of oxygen-deficient atmospheres in the event of functioning of cylinder or manifold pressure-relief devices.</p> <p>d. Air compressors and vacuum pumps shall be located separately from cylinder patient gas systems or cylinder storage enclosures. Air compressors shall be installed in a designated mechanical equipment area, adequately ventilated and with required services.</p> <p>a. Walls, floors, ceilings, roofs, doors, interior finish, shelves, racks, and supports of and in the locations cited in 4-3.1.1.2(a) 10a shall be constructed of noncombustible or limited-combustible materials.</p> <p>b. Locations for supply systems for oxygen, nitrous oxide, or mixtures of these gases shall not communicate with anesthetizing locations or storage locations for flammable anesthetizing agents.</p> <p>c. Enclosures for supply systems shall be provided with doors or gates that can be locked.</p> <p>d. Ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5ft (1.5 m) above the floor to avoid physical damage.</p>	K 143	

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K 143	<p>Continued From page 27</p> <p>e. Where enclosures (interior or exterior) for supply systems are located near sources of heat, such as furnaces, incinerators, or boiler rooms, they shall be of construction that protects cylinders from reaching temperatures exceeding 130°F (54°C). Open electrical conductors and transformers shall not be located in close proximity to enclosures. Such enclosures shall not be located adjacent to storage tanks for flammable or combustible liquids.</p> <p>f. Smoking shall be prohibited in supply system enclosures.</p> <p>Copyright NFPA</p> <p>g. Heating shall be by steam, hot water, or other indirect means. Cylinder temperatures shall not exceed 130°F (54°C).</p> <p>(b) Additional Storage Requirements for Nonflammable Gases Greater Than 3000 ft (85 mi).</p> <p>1. Oxygen supply systems or storage locations having a total capacity of more than 20,000 ft (566 m (NTP), including unconnected reserves on hand at the site, shall comply with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites.</p> <p>2. Nitrous oxide supply systems or storage locations having a total capacity of 3200 lb (1452 kg) [ ft (793 m (NTP)) or more, including unconnected reserves on hand at the site, shall comply with CGA Pamphlet G-8.1, Standard for the Installation of Nitrous Oxide Systems at Consumer Sites.</p> <p>3. The walls, floors, and ceilings of locations for supply systems of more than 3000 ft (85 m total capacity (connected and in storage) separating the supply system location from other occupancies in a building shall have a fire resistance rating of at least 1 hour. This shall also</p>	K 143		

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K 143	Continued From page 28 apply to a common wall or walls of a supply system location attached to a building having other occupancy. 4. Locations for supply systems of more than 3000 ft (85 m total capacity (connected and in storage) shall be vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent opening or openings shall be a minimum of 72 in. (0.05 m in total free area. (c) Storage Requirements for Nonflammable Gases Less Than 3000 ft (85 m- Doors to such locations shall be provided with louvered openings having a minimum of 72 in. (0.05 m in total free area. Where the location of the supply system door opens onto an exit access corridor, louvered openings shall not be used, and the requirements of 4-3.1.1 .2(b)3 and 4 and the dedicated mechanical ventilation system required in 4-3.1.1 .2(b)4 shall be complied with.	K 143		
K 147 SS=E	NFWA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	1. Dietary Director removed the items stored in front of the electrical panel located in the Dietary Manager's office on 04/24/2012.	
	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 four (4) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty five (55) on the day of the survey.		2. Powerstrip located in the storage room off the kitchen was removed and Maintenance Director installed plug in space on 05/01/2012. 3. Maintenance Director removed powerstrip in Med Room on 04/24/2012. 4. Maintenance Director removed powerstrip in room #29 on 04/26/2012.	

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K 147 (continued from page 29)

The findings include:

Observations, on 04/24/12 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed:

- 1) Storage in front of electrical panels located in the Dietary Managers Office.
- 2) A refrigerator and a freezer were plugged into a power strip located in the storage room off of the Kitchen.
- 3) Lift battery chargers were plugged into a power strip located in the Med Room.
- 4) An air conditioning unit was plugged into a power strip located in room 29.
- 5) A mini nebulizer, and a CPAP machine were plugged into a power strip located in room #30.
- 6) Storage in front of electrical panels located in the Business Office Closet.
- 7) A sump pump and two (2) laundry soap dispensing pumps were plugged into a power strip located in the Laundry Room.

Interview, on 04/24/12 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed they were not aware of the storage in front of electrical panels, or the misuse of power strips.

Reference: NFPA 99 (1999 edition)

3-3.2.1.2 D

Minimum Number of Receptacles. The number

5. Maintenance Director removed powerstrip in Room# 30 on 04/25/2012.

6. Maintenance Director removed all items within 3 foot of electrical panels located in the business office closet.

7. Maintenance Director removed the powerstrip in the laundry room.

8. The Maintenance Director checked the entire building for powerstrips and checked storage spaces located around all electrical panels for correct clearance.

9. The Maintenance Director will check building monthly to ensure compliance with storage spaces near electrical panels and will check for any unauthorized powerstrips.

10. The Maintenance Director will report findings to the Administrator monthly and will be reviewed at the monthly QA meeting for 12 months.

06/30/2012

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K 147	<p>Continued From page 30</p> <p>of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around 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>	K 147	