

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

PRINTED: 04/30/2010
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 04/16/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR GLASGOW, KY 42144
---	--



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS An annual survey was conducted on 04/14/10 through 04/16/10 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements with the highest S/S of an "F".	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being were provided for one resident (#3) in the selected sample of 15. Resident #3 was not assessed for pain and for the need for routine use of a pain patch. Findings include: A record review revealed Resident #3 was admitted with diagnoses to include Dementia, Osteoarthritis, Osteoporosis and two Stage IV Pressure Sore. An observation of the resident, on 04/14/10 at 12:32 PM, revealed the resident was sitting in a wheel chair, dressed and groomed. No evidence of pain was observed by the resident's facial or	F 309	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. <u>F309</u> A pain assessment will be completed by the Director of Nursing or other registered nurse on Resident #3 to determine appropriateness of routine pain medication and will continue to be reassessed by a registered nurse, the RAI Coordinator, per our revised pain management policy. All residents who receive pain medications will be reassessed by a registered nurse, the Director of Nursing, using our revised pain management policy. The Director of Nursing will update our pain management program's policy and procedures. The revised policy will include a pain assessment schedule which will mirror the MDS assessments: on admission, quarterly, and with significant change. This will be the schedule used to complete the pain assessment. The revised pain management policy will enable the facility to achieve continued compliance with 483.25, so that each resident will receive the necessary care and services to be able to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility's Quality Improvement Committee will review and approve the contents of the revised pain management program, and make suggestions of any changes/modifications or updates. The Quality Improvement committee, on a quarterly basis, will review the pain assessments for completion to insure compliance with the revised pain management program. Date of Completion: May 28, 2010	5/28/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/20/10
---	------------------------	----------------------

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

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

PRINTED: 04/30/2010
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 04/16/2010
--	--	--	--

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
--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 1</p> <p>verbal expression. The resident was alert and oriented to name. He/she was not interviewable due to his/her impaired cognitive status.</p> <p>A review of the admission Minimum Data Set (MDS), dated 01/30/10, revealed the facility identified Resident #3 as moderately cognitively impaired. He/she was assessed as having mild pain, less than daily with no source of the pain identified on the MDS.</p> <p>A review of the physician's orders, dated March 2010, revealed Fentanyl (narcotic) 12 micrograms (mcg)/hour patch to be applied topically every three days for pain with no source or type of pain identified.</p> <p>A record review revealed no pain assessments were documented by a licensed nurse related to the administration of the routine pain medication and no follow-up assessments related to the effectiveness of the medication.</p> <p>A review of the undated Policy for "Pain Management" revealed a licensed nurse would assess each resident for pain to include the type, frequency and location of the pain upon admission, readmission and with each MDS assessment.</p> <p>An interview with Registered Nurse (RN) #1, on 04/15/10 at 1:20 PM, revealed there were no pain assessments provided by the licensed staff on admission, quarterly or when routine and/or as needed (prn) pain medications were given and there was no monitoring for the effectiveness of the pain medication.</p> <p>An interview with the MDS Coordinator, on</p>	F 309		
-------	---	-------	--	--

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

PRINTED: 04/30/2010
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 04/16/2010
--	--	--	--

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
--------------------	--	---------------	---	----------------------

F 309 Continued From page 2
04/16/10 at 12:25 PM, revealed no formal pain assessment on admission or quarterly was provided for Resident #3. She talked to every resident 1:1 prior to completing a MDS assessment and visually noted any pain the resident exhibited, if that resident was unable to verbalize pain. She looked at the nurse's notes and the Medication Administration Record (MAR) to check for documentation related to pain. The "assessment" was the information she received from the resident and the documentation.

An interview with the Director of Nursing, on 04/16/10 at 10:00 AM, revealed the facility licensed staff did not complete an admission or quarterly pain assessment on residents. The MDS coordinator was the responsible person to assess the resident on admission and quarterly. Signs and symptoms of pain and the effectiveness of the medication was documented in the nurses' notes and/or on the back of the MAR by the appropriate staff.

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
SS=D

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to provide supervision to prevent accidents for one

F 309

F 323
The speech therapist updated the resident's diet order on 4/16/10 to a mechanical soft diet with thin liquid, and removed the no bread restriction. The resident also had his care plan updated to include every 15 minute checks from nursing. The break room door will be closed to prevent further incidents of this type.

Residents with restrictive diets have been evaluated by a registered nurse, the Director of Nursing, for compliance with their diets and any concerns/modifications of the resident's diets will be communicated to the speech therapist for consideration. In addition, the facility will provide retraining by the Director of Nursing on the residents who currently have restrictive diets on 5/21/10.

The facility will provide retraining by the Director of Nursing to employees on residents with restrictive diets on 5/21/10. The facility will also keep the break room door closed to prevent further incidents of this type, by having a door closure installed on the door to keep the door closed. The door closure has already been installed on the door.

The Quality Improvement committee will review residents with restrictive diets and their compliance during the committee's regular quarterly meetings.

Date of Completion: May 28, 2010

5/28/10

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

PRINTED: 04/30/2010
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 04/16/2010
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	
F 323	<p>Continued From page 3</p> <p>resident (#11), in the selected sample of 15. Resident #11 was observed in the main dining room stuffing a doughnut into his/her mouth and staff failed to intervene. Resident #11's diet order was identified as a mechanical soft diet with thickened liquids and no bread products. Findings include:</p> <p>A record review revealed Resident #11 was admitted to the facility with diagnoses to include Profound Mental Retardation, Chronic Renal Failure and Parkinson's Disease. A review of the Nursing Admission Assessment, dated 03/26/10, revealed the resident had a feeding tube and was receiving Nepro bolus feedings, one can five times a day and the resident had orders to remain NPO (nothing by mouth).</p> <p>A review of the Speech Therapy Evaluation and Plan of Treatment, dated 03/29/10, revealed the resident had a diagnosis of Dysphagia (difficulty swallowing). The long term goal was that Resident #3 would tolerate the least restrictive diet without signs or symptoms of aspiration/choking. The short term goal stated staff would utilize strategies to increase safety/independence with the least restrictive diet.</p> <p>A review of the Speech Therapy Treatment notes, from 03/31/10 through 04/12/10, revealed the resident was included in the facility's restorative dining program and was being carefully monitored by speech therapy regarding consistency of foods, liquids and intake.</p> <p>A review of the comprehensive care plan, dated 04/02/10, revealed the resident was "at risk for nutritional alteration and choking, related to severe mental retardation and swallowing and</p>	F 323			

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

PRINTED: 04/30/2010
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 04/16/2010
--	--	--	--

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
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 4</p> <p>chewing problems". Care Plan interventions included "provide diet per physician's orders".</p> <p>A review of the physician's orders, dated April 2010, revealed the resident's diet was changed from NPO to a mechanical soft diet with no bread, on 04/01/10. A review of the undated Certified Nurse Aide (CNA) assignment sheet revealed Resident #11 could not have bread and was on every one hour safety checks.</p> <p>An observation, on 04/14/10 at 9:40 AM, revealed Resident #11 was in the dining room with food running down from his/her mouth. The nursing staff stated Resident #11 grabbed food from another resident's tray, while being escorted back to the restorative dining room.</p> <p>On 04/15/10 at 7:30 AM, Resident #11 was observed walking in the dining area and had a half of a donut in his/her right hand and was chewing. No staff were observed to intervene to remove the donut from the resident's mouth or hand.</p> <p>An interview with the Dietary Manager, on 04/16/10 at 10:40 AM, revealed she had observed Resident #11 eating a donut on 04/15/10 at 7:20 AM. She "did not think" of Resident #11's diet during the observation of the resident eating the donut, but was aware Resident #11 was on a mechanical soft diet with no bread.</p> <p>An interview with the Speech Therapist (ST), on 04/16/10 at 10:45 AM, revealed she could not recall Resident #11's diet of mechanical soft with no bread. Resident #11 was suppose to eat in the restorative dining room, with supervision. The ST</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 04/30/2010
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 04/16/2010
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)	(X5) COMPLETION DATE
F 323	Continued From page 5 stated she was aware Resident #11 shoved food into his/her mouth and the ST revealed monitoring Resident #11 was difficult, due to his/her behaviors. An interview with Registered Nurse (RN) #1, on 04/16/10 at 11:03 AM, revealed she was unaware. Resident #11 had eaten a donut on 04/15/10 at 7:30 AM. However, she had observed Resident #11 eating bacon taken from another resident's tray previously and had taken the resident into his/her room and removed the bacon from his/her mouth. RN #1 stated the staff were "doing their best" to keep Resident #11 away from inappropriate foods. An interview with the Administrator, on 04/16/10 at 11:10 AM, revealed the staff were "trying to keep a close eye" on Resident #11. The Administrator revealed he was informed on 04/15/10 in the afternoon that Resident #11 had entered the employee lounge and taken a donut. An observation on 04/14/10 at 11:56 AM and on 04/16/10 at 10:40 AM by the surveyor revealed the employee lounge was open and unattended.	F 323	The facility has implemented a plate heating system which should help with the food temperatures immediately. We have also ordered an additional enclosed tray cart on 5/10/10. The meal carts will be delivered within 6 minutes of the loading of the carts. The meal delivery system is being changed by adding the additional enclosed cart which has been ordered. Also, we are sending only a certain number of trays, twelve trays, out on the first cart, and then sending the remainder of the trays on the enclosed cart, until the second enclosed cart arrives at the facility. When we get the second enclosed cart, we will have two enclosed carts to deliver the trays. We have talked to both nursing and dietary about the importance of communicating with one another about the delivery of meal trays, in the inservice training on 5/21/10. In addition, the breakfast trays are having their eggs placed in an insulated bowl to keep the eggs warmer during meal delivery, and then placed on the plate with delivery. The facility's staff, along with the dietary manager, will continue to monitor all residents for proper food temperatures through our daily interaction. Any temperature complaints by residents will be logged on a complaint form by facility staff, including the dietary manager and the dietary manager will complete any necessary interventions. The facility's staff will continue to discuss food temperatures in the resident council meeting on a monthly basis. The dietary manger will be closely monitoring the temperatures of the resident foods through random test trays throughout the week, and document her findings. The facility's dietary manager will be monitoring food temperatures by completing test trays at different times and days throughout the week. The dietary manager will immediately follow up on any complaints which are addressed through a complaint form. The facility has immediately implemented a plate warming system. The meal delivery system is being changed by adding the additional enclosed cart which has been ordered. Also, we are sending only a certain number of trays, twelve trays, out on the first cart, and then sending the remainder of the trays on the enclosed cart, until the second enclosed cart arrives at the facility. When we get the second enclosed cart, we will have two enclosed carts to deliver the trays. We have talked to both nursing and dietary about the importance of communicating with one another about the delivery of meal trays, in the inservice training on 5/21/10. In addition, the breakfast trays are having their eggs placed in an insulated bowl to keep the eggs warmer during meal delivery, and then placed on the plate with delivery. The quality improvement committee will review the food temperatures and also review any complaints on food temperatures which are documented on the complaint forms. The quality improvement committee will insure that the dietary manager has provided an appropriate follow-up to the food temperature complaints.	
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP. Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record	F 364		5/28/10 Date of Completion: May 28, 2010

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

PRINTED: 04/30/2010
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 04/16/2010
--	--	--	--

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
--------------------	--	---------------	---	----------------------

F 364	<p>Continued From page 6</p> <p>review, it was determined the facility failed to provide food at the proper temperature related to complaints of cold food temperatures for breakfast on 04/15/10 at 7:31 AM, at the point of service. A review of the Census and Conditions form, dated 04/14/10, revealed the facility census was 59. It was determined 49 of 59 residents ate food prepared and served from the facility kitchen.</p> <p>Findings include:</p> <p>Review of the undated Meal Service, Supplements, and Substitutions policy revealed the nursing personnel would deliver the trays to the residents as quickly as possible to ensure food was served at appropriate temperature (Palatable).</p> <p>A review of the Resident Council Meeting minutes, dated 02/10/10, revealed the residents complained of the eggs being cold at breakfast. On 03/10/10, the residents complained breakfast should be warmer. Interviews with the Resident Council, on 04/14/10 at 2:00 PM, revealed four of five residents in attendance, voiced cold food temperatures at breakfast continued to be a problem.</p> <p>Observations of the tray line temperatures, on 04/15/10 at 7:00 AM, revealed the scrambled eggs were at 180 degrees F, pureed eggs were 170 degrees F, sausage was 160 degrees F, ground sausage was 170 degrees F and the gravy was 180 degrees F. Observation revealed the meals were served on plates and covered by a plate cover. On 04/15/10 at 7:30 AM, a test tray was placed on an open cart. The staff began serving the meal from the cart at 7:25 AM and the test tray temperatures were obtained at 7:31</p>	F 364		
-------	---	-------	--	--

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

PRINTED: 04/30/2010
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 04/16/2010
--	--	--	--

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
--------------------	--	---------------	---	----------------------

F 364 Continued From page 7
AM. The temperatures of the food at the point of service revealed scrambled eggs were 100 degrees Fahrenheit (F); pureed eggs were 90 degrees F; sausage was 80 degrees F; ground sausage was 82 degrees F and the gravy was 108 degrees F.

An interview with the Dietary Manager (DM), on 04/15/10 at 12:30 PM, revealed food was warm when it left the kitchen. The DM stated nursing staff "took their time" to pass out the trays and she felt the delay could be part of the problem. She stated breakfast food got cold quickly.

An interview with the Administrator, Director of Nursing and the DM, on 04/16/10 at 10:00 AM, revealed a test tray was obtained on 03/16/10 that revealed the food temperatures for eggs was 102 degrees F, gravy was 112 degrees F and ground sausage was 98 degrees F at the point of service. No explanation was given why the food temperatures continued to be lower.

F 364

F 371
SS=F 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observations, interview and record

F 371

F371
On 4/14/2010, there were no negative resident outcomes related to the meal service.

Again, no negative resident outcomes have been identified, no food contamination issues, or food borne illness issues have been identified by the facility. The facility's Infection Control committee will continue to monitor the facility for any signs of food contamination or food borne illnesses.

The facility will provide an additional 4 hours of Food Safety/Sanitation instruction to all of the dietary staff. The Registered Dietitian, a ServSafe instructor, will perform training on 5/21/10. The Dietary Manager, along with the RD, will continue to monitor dietary staff for proper food handling and sanitary food techniques. The Dietary Manager will complete a weekly sanitation audit, and the RD will complete a monthly sanitation audit. The dietary manager will immediately address any area which are identified throughout the week, and document them on her weekly audit tool.

The quality improvement committee will review the findings of the audits done by the dietary manager and registered dietitian.

Date of Completion: May 28, 2010

5/28/10

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

PRINTED: 04/30/2010
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 04/16/2010
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
F 371	<p>Continued From page 8</p> <p>review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. A review of the Census and Conditions form, dated 04/14/10, revealed the facility census was 59. It was determined 49 of 59 residents ate food prepared and served from the facility kitchen.</p> <p>Findings Include:</p> <p>Review of the undated Sanitation and Food Handling policy revealed sanitary conditions would be maintained in the storage, preparation, and distribution of the food and the personnel would observe personal cleanliness and exercise satisfactory food handling techniques. The procedure revealed the dietary manager was responsible for supervising the sanitation within the department. The policy stated employees must wash hands after touching their hair, nose or other body parts.</p> <p>Observations, on 04/14/10 at 11:30 AM and on 04/15/10 at 7:05 AM, revealed server #1 touched her apron while working on the tray line during food preparation and did not wash her hands before returning to the tray line. On 04/15/10 at 7:15 AM, server #2 touched her chest and then touched the bread slices without washing her hands.</p> <p>Interviews with the Dietary Manager, on 04/15/10 at 12:30 PM and the Administrator on 04/15/10 at 12:46 PM, revealed they expected dietary staff to wash their hands after touching their apron and chest during the tray line before returning to the tray line.</p>	F 371		

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

PRINTED: 04/30/2010
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/14/2010
--	--	--	--

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	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 04/14/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an F.	K 000		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 04/14/10, it was determined the facility failed to ensure decorations used in the facility were flame-retardant as required by NFPA 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Observations during the Life Safety Code tour, conducted on 04/14/10, at 3:15 PM, revealed doors throughout the facility were decorated with wreaths. Stuffed animals were noted to be throughout the facility and there was no documentation to indicate the stuffed animals had been sprayed with a flame-retardant. An interview conducted with the Maintenance Director, on 04/14/10 at 3:30 PM, revealed the wreaths had been put on the doors by family members, the facility did not have any documentation that would indicate the flame rating of the wreaths on the doors or	K 073	<u>K073</u> All furnishings and decorations of a highly flammable character will be identified in the facility. These items will be sprayed with a flame retardant solution. A log of the flammable items that have been sprayed will be kept by the maintenance department and will be updated on a monthly basis to insure that new items are identified and sprayed. The admissions staff will communicate to resident families on admission what our policy is regarding the spraying of items. The quality improvement committee will review the documentation from the maintenance department to insure continued compliance and keep this violation from reoccurring. Date of Completion: May 28, 2010	5/28/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *5/10/10*

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

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

PRINTED: 04/30/2010
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/14/2010
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 073	Continued From page 1 documentation indicating the stuffed animals had been treated.	K 073			