

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

PRINTED: 04/03/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/20/2012
NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An abbreviated survey (KY #18015) was conducted on 03/20/12 to determine the facility's compliance with Federal requirements. KY#18015 was substantiated with deficiencies cited at the highest scope and severity of a "D."	F 000	<i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i>	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's	F 157	<i>Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.</i>  F - 157 1. On 2-28-2012 the stop sign was d/c from resident #1 doorway and careplan was updated by nursing staff. Family was notified of this change. 2. A review of physicians orders, 24 hour reports, and reports of all incidents for past 30 days will be completed by 4-12-12 by administrative nurses to ensure that all notifications to physicians and responsible parties occurred as indicated. 3. Facility nurses were re-educated by facility ADON of notification of change and the importance of a notification of change. This was completed on 4-4-2012. All newly hired nurses will be educated on this policy during orientation. 4. A facility Quality Assurance audit will be completed of all physician orders, 24 hour reports and reports of incidents weekly for 4 weeks then monthly for 3 months then	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David A. Gant TITLE: Administrator (X6) DATE: 4-10-12

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

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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	
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F 157	<p>Continued From page 1 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to notify the resident's legal representative when a stop sign gate was placed on the resident's doorway for one resident (#1), in the selected sample of five residents.</p> <p>Findings include:</p> <p>An interview with the Director of Nursing (DON), on 03/20/12 at 5:10 PM, revealed she was unable to provide a policy/procedure related to family notification.</p> <p>A record review revealed the facility admitted Resident #1 on 02/19/08 with diagnoses to include Crush Injury to Neck, Tracheostomy, Gastrostomy, Mental Disorder and Depression.</p> <p>A review of the Comprehensive Care Plan, dated 02/16/12, revealed an intervention, to place a stop sign across the resident's doorway to prevent wanderers from entering the room, was added to the care plan.</p> <p>A review of the nurse's notes, dated February 2012, revealed there was no evidence the facility notified the family that the stop gate was placed on Resident #1's doorway.</p> <p>An interview with the complainant, on 03/19/12 at 9:20 AM, revealed he/she visited Resident #1, on 02/26/12, and there was a stop gate across</p>	F 157	<p><i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i></p> <p><i>Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</i></p> <p><i>To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.</i></p> <p>quarterly an audit of a 30 day period will be completed to ensure physician and family notification is taking place as needed. Any negative findings will result in re-education of the nurse involved immediately. The findings will be reported to the Quality Assurance Committee no less than quarterly.</p> <p>5. Completion Date 4-13-12</p> <p>F - 281</p> <ol style="list-style-type: none"> <li>1. The Feeding was immediately removed from the room of resident #1 and discarded and new feeding hung per LPN on 3-20-2012.</li> <li>2. An audit was completed by facility ADON of the feedings in-house to ensure that no further expired feedings existed on 3-20-2012.</li> <li>3. Facility ADON will check feedings as delivered weekly to ensure that feedings</li> </ol>

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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. 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 157	Continued From page 2 Resident #1's doorway. The complainant stated he/she thought the resident "had contracted something contagious" and went to the nurse's desk to find out about it. The nurse at the desk told him/her the gate was placed to keep a wandering resident from entering Resident 1's room.  An attempt was made, on 03/20/12 at 3:00 PM, to interview the nurse who was responsible to contact the family about the stop gate; however, the attempt was unsuccessful.  An interview with the Director of Nursing (DON), on 03/20/12 at 4:20 PM, revealed the nurse did not notify the family about the stop gate being placed on Resident #1's doorway. She stated the nurse should have notified the family about the stop gate.	F 157	<i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.</i>	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  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 and record review, it was determined the facility failed to ensure licensed staff checked the expiration date on a tube feeding prior to the administration of the tube feeding for one resident (#1), in the selected sample of five residents.  Findings include:  An interview with the Director of Nursing (DON),	F 281	have not exceeded their expiration date. ADON will also monitor storage room weekly to ensure that feedings have not exceeded their expiration date. Facility nurses were re-educated on 4-4-2012 by the ADON as to the importance of the expiration date and were reminded to check feedings before they hang them to ensure that the expiration date is not exceeded. 4. A Quality Assurance study will be performed by facility Restorative nurse weekly X 12 for expired feedings until substantial compliance is achieved. The findings will be reported to the Quality Assurance Committee no less than quarterly. 5. Completion Date: 4-5-12	

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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. 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 281	<p>Continued From page 3</p> <p>on 03/20/12 at 4:20 PM, revealed there was no policy and procedure to address the licensed nurses checking the expiration date and no professional standards of practice were provided by the facility. She stated licensed staff were taught in nursing school to always check the expiration dates on feedings and medications.</p> <p>A record review revealed the facility admitted Resident #1 on 02/19/08 with diagnoses to include Surgical Complications, Pneumonia, Crush Injury Neck, Tracheostomy, Gastrostomy, Opioid Dependence, Hypertension (HTN), Mental Disorder and Depression.</p> <p>A review of the physician's order, dated February 2012, revealed an intervention to administer Jevity 1.2 at 60 milliliters (ml)/hour continuously for twenty-four (24) hours.</p> <p>Observations, on 03/20/12 at 11:30 AM and 1:20 PM, revealed Resident #1 was receiving Jevity 1.2 at 60 ml/hour per tube feeding. The expiration date on the bottle was 03/01/12.</p> <p>An interview with the complainant, on 03/19/12 at 9:20 AM, revealed when he/she visited Resident #1, on 02/26/12, he/she identified the bottle of Jevity 1.2 which hung on the feeding pump with an expiration date of 02/01/12. There were two bottles of Jevity 1.2 on the bedside table with the same expiration date.</p> <p>An interview with a Registered Nurse (RN) and a Licensed Practical Nurse (LPN), on 03/20/12 at 4:50 PM and 4:55 PM, respectively, revealed licensed staff should check the expiration date before hanging the feedings.</p>	F 281		

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F 281	Continued From page 4  An interview with the DON, on 03/20/12 at 4:20 PM, revealed Resident #1's family member did identify a bottle of Jevity with an expiration date of 02/01/12. There was also additional bottles on the bedside table with the same expiration date. She stated she did not determine who had administered the feeding and no action was taken to ensure the licensed nurses checked the expiration date prior to administration of the feeding.	F 281		

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/20/2012
NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. 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) COMPLETE DATE
N 000	INITIAL COMMENTS  A complaint survey (KY #18015) was conducted on 03/20/12 to determine the facility's compliance with State requirements. KY#18015 was substantiated with deficiencies cited.	N 000	<i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i>	
N 019	902 KAR 20:300-3(2)(i)1.c. Section 3. Resident Rights  (2) Notice of rights and services. (i) Notification of changes. 1. Except in a medical emergency or when a resident is incompetent, a facility shall consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within twenty-four (24) hours when there is: c. A need to alter treatment significantly; or  This requirement is not met as evidenced by: Based on interview and record review, it was determined the facility failed to notify the resident's legal representative when a stop sign gate was placed on the resident's doorway for one resident (#1), in the selected sample of five residents.  Findings include:  An interview with the Director of Nursing (DON), on 03/20/12 at 5:10 PM, revealed she was unable to provide a policy/procedure related to family notification.  A record review revealed the facility admitted Resident #1 on 02/19/08 with diagnoses to include Crush Injury to Neck, Tracheostomy, Gastrostomy, Mental Disorder and Depression.  A review of the Comprehensive Care Plan, dated	N 019	<i>Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</i> <i>To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.</i>  N - 019 1. On 2-28-2012 the stop sign was d/c from resident #1 doorway and careplan was updated by nursing staff. Family was notified of this change. 2. A review of physicians orders, 24 hour reports, and reports of all incidents for past 30 days will be completed by 4-12-12 by administrative nurses to ensure that all notifications to physicians and responsible parties occurred as indicated. 3. Facility nurses were re-educated by facility ADON of notification of change and the importance of a notification of change. This was completed on 4-4-2012. All newly hired nurses will be educated on this policy during orientation. 4. A facility Quality Assurance audit will be completed of all physician orders, 24 hour reports and reports of incidents weekly for 4 weeks then monthly for 3 months then	



*Darrell W. Covert*

Administrative

4-10-12

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

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34T611

If continuation sheet 1 of 4