

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/02/2011
NAME OF PROVIDER OR SUPPLIER GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE P.O. BOX 189 GLASGOW, KY 42141	
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F 000	INITIAL COMMENTS  An abbreviated survey (KY #15310) was conducted on 03/01-02/11 to determine the facility's compliance with Federal Regulations. The allegation was substantiated and deficient practice was identified at 483.13 (F-226) at a scope and severity of D.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation and reporting of abuse, neglect, mistreatment, and misappropriation of property for one resident (#1), in the selected sample of three. The facility failed to thoroughly investigate and report an incident of potential verbal abuse. Findings include:  The facility's policy "Safe Environment," revised 09/13/09, revealed the facility maintained a safe environment for residents entrusted to their care. The policy included the elements of prevention, screening, identification, training, protection, investigation, reporting/responding and implementation of effective actions to protect persons served. The policy/procedure revealed the facility established definitions in the area of abuse, neglect and potentially serious	F 226	<b>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</b>  Social Services interviewed resident #1 utilizing the CQI Quality of Life/Resident Interview questionnaire tool on 03/07/11 and 03/21/11. Questions included but were not limited to: Question #1 Do you receive assistance daily with dressing and grooming? Question #2 Does staff treat you with respect? Question #9 Is your call light answered in a timely manner? Question #11 Do you feel like you can voice concerns/complaints to the staff in the facility without discrimination or reprisal? Question #12 Does the facility address your concerns/resolve complaints in a timely manner? Question #21 Do you have any concerns with how anyone has talked with you or provided you care?  Interdisciplinary care team reviewed and revised resident #1 care plans and assignment sheet on 3/9/11 and 03/23/11 to include a grieving care plan over the loss of his mother, encourage him to report concerns to the charge nurse and dissatisfaction with placement care plan.  Social Service staff member completed the PHQ9 assessment with resident #1 on 03/14/11. Resident requested to attend an outing with a specific individual and to live closer to his family. Resident #1 guardian arranged the outing for 03/24/11 and social service staff continues to refer him to other facilities closer to his family.	03/30/11

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

*Rebecca Jandy* Facility Director 3/24/11

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 226	<p>Continued From page 1</p> <p>injury. When the facility discovered the defined conditions the incident should be reported to the State Agency. The definition for verbal abuse included any use of oral, written or gestured language that willfully included disparaging and derogatory terms to individuals or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Verbal abuse also included any pejorative and derogatory terms to describe individuals with disabilities. The policy identified a classification of incidents according to the potential for harm to the individual and carried protocols for recording and follow-up. The most serious incidents were to be classified as class three, which included reported, alleged or suspected abuse, neglect or exploitation. Class three incidents required an investigation to be completed and follow-up reported to the State Agency.</p> <p>A record review revealed Resident #1 was admitted to the facility 03/03/10, with diagnoses to include Episodic Mood Disorder, Adjustment Disorder Unspecified and Crohn's Disease.</p> <p>The admission Minimum Data Set (MDS) assessment dated 03/16/10, revealed the facility identified Resident #1 as modified independent for daily decision making. The quarterly MDS dated 11/22/10 revealed a score of fourteen (14) on the brief interview for mental status (BIMS). A score of 13-15 on the BIMS indicated the resident was independent for daily decision making.</p> <p>An interview with Certified Nursing Assistant (CNA) #7, on 03/01/11 at 10:42AM revealed she assisted Resident #1 with a bath on 07/05/10 and the resident</p>	F 226	<p><b>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</b></p> <p>Social Services Director or Director of Nursing completed the CQI Quality of Life/Resident Interview questionnaire on all fifty-two interviewable residents by 03/23/11. During the individual interviews, a copy of the Resident Rights was offered to all residents. Individual resident care plans and assignment sheets will be reviewed and revised as indicated. Incident Reports were completed if a resident voiced a concern or complaint with care. The CQI Quality of Life/Resident Interview answers were summarized and will be reviewed and discussed during the 04/13/11 CQI meeting.</p> <p>In the event a resident alleges abuse, neglect or exploitation, the allegation will be immediately reported to the Office of Inspector General and Department for Community Based Services. In addition, the facility will assess the resident, complete an incident report, contact the guardian and physician, and conduct an investigation. Interviews of other residents potentially affected by the alleged abuse or neglect will be completed. Findings of the investigation will be forwarded to the Office of Inspector General and Department of Community Based Services within five working days.</p> <p><b>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</b></p> <p>The Facility Director, Facility Superintendent Associate and Risk Manager attended the Abuse &amp; Neglect Training conducted by the Office of Inspector General on 03/10/11. The Abuse Reporting Process was discussed in the in-service.</p>	

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F 226	<p>Continued From page 2</p> <p>told her a CNA yelled at him/her for being incontinent. CNA #7 reported the allegation to her supervisors immediately.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 03/01/11 at 3:10 PM, revealed CNA #7 informed her that Resident #1 was upset with another CNA several months ago, due to the manner the staff spoke to the resident. CNA #7 revealed the resident told her that CNA #1 told the resident he/she made more work for her, due to an incontinent episode. LPN #1 spoke to the resident and was informed of the same information as received by CNA #7. LPN #1 reported the incident to the nurse supervisor; however, she could not recall the exact date.</p> <p>An interview with Registered Nurse (RN) #2, on 03/01/11 at 3:30 PM, revealed LPN #1 contacted her the night the allegation was reported. However, she had not received training in the investigative process at the time and she contacted her preceptor, RN #3. RN #2 was unsure whether the alleged perpetrator was removed from resident care at the time the allegation was reported. She stated the allegation should have been considered a potential abusive situation, until an investigation was completed.</p> <p>An interview with RN #3, on 03/02/11 at 10:00 AM, revealed she spoke to Resident #1 the night the allegation was reported. The resident stated he/she was unsure who made the statement, but was told he/she caused a CNA to work extra as a result of an incontinent episode. RN #3 revealed she was not aware of the allegation, until change of shift and the CNA had already left the facility. She stated the incident should have been treated as a potential verbal abuse situation. RN #3 revealed any potential abusive</p>	F 226	<p>All staff (state and contract) will be in-serviced on Resident Rights, Employee Conduct, and Facility Policy AG-002 Safe Environment by 03/25/11. Staff members on leave will receive the in-service before resuming their assigned duties. Facility Policy AG-002 Safe Environment states "it is the responsibility of any staff member to make a verbal report about an incident, as defined in this protocol, to the immediate supervisor as soon as it is discovered. A follow up written report of the incident shall be initiated before the end of the shift of discovery utilizing a standardized incident report format".</p> <p>New employees (state and contract) will receive training on Resident Rights, Employee Conduct and Facility Policy AG-002 Safe Environment in orientation before beginning their assigned duties.</p> <p>The facility has trained investigators to conduct thorough investigations of alleged abuse, neglect or exploitation. Refresher investigation training by Vera Frasier, Certified Investigator, was conducted on 03/23/11 for all facility investigators to review the investigative process.</p> <p><b>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</b></p> <p>An incident report is completed by the licensed nurse when a resident alleges abuse, neglect or exploitation. The incident report is completed on the shift of occurrence and the form provides a block for suspected or alleged abuse or neglect. If the box is checked, the staff is directed to notify the Facility Director or the Administrator-on-call immediately.</p>		

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F 226	<p>Continued From Page 3</p> <p>situation should be investigated thoroughly and the staff should be removed from resident care until the investigation was completed. She was unsure if the Administrator on call was contacted the night the allegation was made.</p> <p>An interview with the Director of Risk Management, on 03/01/11 at 4:00 PM, revealed when an allegation was made with the potential to be an abusive situation, the facility process included an initiation of an investigation to determine the level of the allegation. She stated all class three allegations were reported to the State Agency.</p> <p>An interview with the facility Director on 03/01/11 at 4:10 PM revealed the facility contacted her the night the allegation was made. She stated the CNA had already left the building when she was contacted and did not return to work until the investigation was completed. The Director stated no one ever used the term "abuse" or "possible abuse" when the incident was reported to her. She revealed the facility completed an investigation, however, the facility did not report the allegation to the State Agency because they did not feel it was an abusive situation, but more an incident of unprofessional conduct. She stated the facility did not interview other residents in the area of the facility to determine whether anyone else was spoken to in an unprofessional manner. The Director stated interviews with other residents in the area would normally be a part of any investigation with the potential to be an abuse situation. She stated the facility completed disciplinary action with CNA #1 regarding resident rights/abuse and neglect.</p>	F 226	<p>The Incident Management Committee reviews all resident incidents from the previous 24 hours including incidents involving resident's allegation of abuse or neglect Monday-Friday and the day shift RN reviews the incidents Saturday-Sunday. The disciplines included in the Incident Management Committee are social services, facility director and/or facility superintendent associate, director of nursing or RN charge nurse, risk management and Administrator on Call.</p> <p>The Facility Director is a member of the Incident Management Committee and is responsible for ensuring all allegations of abuse or neglect are immediately reported to the Office of Inspector General and Department for Community Based Services.</p> <p>All investigations are reviewed by the Incident Management Committee before submitting to the designated state agencies. The Facility Director is a member of the committee and will ensure other residents potentially affected by the alleged abuse or neglect was interviewed during the investigation.</p> <p>The Incident Management Committee monthly compiles a listing of all incidents to include the number and types of reportable incidents to state agencies. Risk management or Facility Superintendent Associate will share the monthly incident management review findings with the interdisciplinary CQI/QA committee.</p> <p>The nurse consultant will review facility alleged abuse and neglect investigations with monthly visits to determine compliance with completion of investigations and reporting to the required state agencies.</p>	

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F 226	<p>Continued From page 4</p> <p>An interview with CNA #1, on 03/02/11 at 11:35 AM, revealed she denied making any inappropriate statements to Resident #1, but acknowledged she received a verbal reprimand from the facility regarding the incident. She stated she received the verbal reprimand because any employee the facility deemed as potentially abuse received the education.</p> <p>A review of the facility's investigation revealed witness statements were obtained from the staff that worked in the area the night the allegation was made. Additionally, an interview with Resident #1 was conducted; however, there was no evidence of interviews with any other residents who had the potential to be affected.</p> <p>A review of CNA #1's personnel file revealed she had received a verbal reprimand on 07/07/10 and was educated on the facility policy regarding abuse and neglect.</p>	F 226		