

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

PRINTED: 11/13/2015
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 R-C 11/13/2015
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 Based on implementation of the acceptable PoC, the facility was deemed to be in compliance on 11/13/15, as alleged.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X8) DATE

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185340	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/13/2015
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Name of Facility GLASGOW HEALTH & REHABILITATION CENTER	Street Address, City, State, Zip Code 220 WESTWOOD ST. GLASGOW, KY 42141
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0241</u> Reg. # <u>483.15(a)</u> LSC _____	Correction Completed 11/13/2015	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 11/13/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>OH</u>	Date: <u>11/13/15</u>	Signature of Surveyor: <u>Deborah C. Herdman</u>	Date: <u>11/13/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 10/9/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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F 000 INITIAL COMMENTS

F 000

An Abbreviated Survey (KY#23882) was conducted on 10/07/15 through 10/09/15. KY#23882 was substantiated with deficient practice identified at the highest Scope and Severity of a "D".

The Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in this Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY
SS=D

F 241

F241

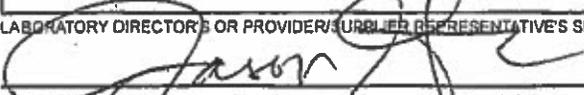
The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

1. Resident #2 scored a 4 (four) on a BIMS score when completed on 10/9/2015 by social services. Resident #2 had documented confusion from the hospital H&P dated 9/27/2015. Resident #7 is severely cognitively impaired as stated in the 2567. Unsampled Resident A was interviewed by social services on 10/9/2015 and stated that he/she had no inappropriate actions by staff or visitors to report.
2. On 10/9/2015, all residents with a BIMS score of 8 or greater were interviewed. The administrator along with social services director interviewed 36 residents and no new allegations were identified during those interviews. In addition, the administrator interviewed eighty (80) staff members to determine if there were any other resident allegations. Employees were asked about any other incidents which were either inappropriate or allegations and also that they were aware of the requirement to report those immediately. After speaking with eighty (80) employees, no new allegations were identified. Residents with BIMS score of less than 8 had a skin assessment completed on 10/9/2015 as well to ensure that residents who were nonverbal were included in the investigation. No new allegations were identified as the result of the skin assessments completed on 10/9/2015. The 24 hour reports were reviewed back for 30 days to identify any changes in behavior for non-interviewable residents and that review yielded no allegations as well.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to interact with residents in a manner which promotes dignity and respect in full recognition of his or her individuality for two (2) residents, in the selected sample of eight (8) residents (Resident #2 and Resident #7), and for one (1) unsampled resident (Resident A), related to inappropriate statements made by Licensed Practical Nurse (LPN) #2.

The findings include:

Review of the facility's policy, "Resident Abuse/Neglect", dated 10/16/12, revealed employees are to ensure that all residents are protected from abuse, neglect and exploitation. Employees of the facility will not willfully inflict any injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, deprivation by an individual of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/3/15
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F 241	<p>Continued From page 1</p> <p>goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being.</p> <p>Record review revealed the facility admitted Resident #2 on 02/28/15 with diagnoses which included Chronic Kidney Disease, Chronic Pulmonary Heart Disease, Anemia, Diabetes, Chronic Peptic Ulcer, Difficulty in Walking, and Muscle Weakness. Review of the quarterly Minimum Data Set (MDS), dated 08/04/15, revealed the facility scored the resident to have a Brief Interview for Mental Status (BIMS) of nine (9). An attempt to interview Resident #2 was made, and when asked if staff ever verbally abused him/her, or spoke "ugly" to him/her, he/she refused to answer the questions.</p> <p>Record review revealed the facility admitted Resident #7 on 05/03/11 with diagnoses which included Intellect Disability, Convulsions, and Hypothyroidism. Review of the quarterly MDS, dated 09/04/15, revealed the facility scored the resident's cognition to be severely impaired.</p> <p>Interview with Unsampled Resident A, on 10/09/15 at 9:10 AM, revealed LPN #2 has "yelled at me" and told the resident, "I'll do what I want, this is my shift." He/she also revealed the LPN reportedly had a "bad attitude" and often spoke in a short tone to the residents. Unsampled Resident A revealed he/she observed LPN #2 hold the arms of another resident, and shake him/her after pacing the halls and sounding the door alarm.</p> <p>Interview with LPN #2, on 10/07/15 at 7:27 PM, revealed she was aware of an incident with Resident #2. She reported she spoke to the</p>	F 241	<p>3. LPN #2 was re-educated on 10/15/2015 regarding customer service, such as how to speak to residents and others professionally, and how to speak to a resident with respect and dignity by the Administrator. LPN #2 position at the facility was re-evaluated and she was placed in a non-supervisory role. Staff were educated on 10/16/2015 on customer service by the Administrator and with respect to enhancing the resident's dignity and well-being. We will continue to educate the employees until all current employees are completed, with no one working after November 13, 2015 without the required education. Newly hired staff will receive training on abuse and customer service during new employee orientation, education will be repeated no less than annually.</p> <p>4. The social service director will interview 5 residents with BIMS scores of 8 or greater each week for 4 weeks, then every other week for 4 weeks, then once a month about their dignity and the staff's respect and treatment. Residents will be asked about dignity and respect from staff during the monthly resident council meetings, monthly for 3 months and then quarterly for one year. The result of these interviews will be reported to the QA committee quarterly and will be discussed in our quarterly QA committee meeting. The QA committee will determine if the interview needs to continue or not and any appropriate action as the result of the interviews.</p> <p>5. Completion Date: November 13, 2015</p> <p style="text-align: right;">11/13/15</p>

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F 241	<p>Continued From page 2</p> <p>resident about the importance of compliance with his/her treatment regimen related to his/her Diabetes. She revealed, at no time did she raise her voice, and stated, "My intent was not to hurt the resident's feelings". LPN #2 revealed the Director of Nursing (DON) spoke with her about the incident the next morning. LPN #2 revealed she was unaware of any allegations made against her. She revealed she could not recall who worked with her on the night in question. As a supervisor, she expected staff to do his or her job. She expected staff to follow rules, stay busy, and not "hang out" at the desk.</p> <p>Telephone interview with the DON, on 10/07/15 at 12:30 PM, revealed it was reported to her that LPN #2 told Resident #2 his/her legs were going to "fall off". This information was reported the next morning; however, the DON could not recall which staff member gave her the information. An incident report was not completed and the DON was unable to provide any documented evidence of an incident.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2, on 10/09/15 at 6:58 AM, revealed she overheard LPN #2 speak sternly to the resident and tell the resident that his/her legs were going to fall off.</p> <p>Interview with SRNA #3, on 10/09/15 at 7:08 AM, revealed she heard LPN #2 tell Resident #2 that his/her legs were going to fall off. She revealed she was also aware LPN #2 told another resident (Resident #7) that she "hates that repetitive stuff" the resident says over and over.</p> <p>Interview with SRNA #4, on 10/09/15 at 7:12 AM, revealed she overheard LPN #2 tell Resident #2</p>	F 241		

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F 241 Continued From page 3

F 241

"I'm surprised you have any legs left". She revealed the LPN was generally rough and abrupt when talking to residents, and the way she worded things was inappropriate.

Interview with SRNA #5, on 10/09/15 at 7:33 AM, revealed she overheard LPN #2 tell Resident #2 his/her "legs were getting so bad that he/she might as well have them cut off." LPN #2 was also heard telling Resident #7, "Why don't you just shut up, you don't have to keep saying it over and over again". She revealed, another time, the LPN made the comment to a resident in pain, "you just need to go ahead and die". She stated LPN #2 has been described as rude to staff and coworkers. She stated she does not like to do her treatments, and rarely goes in to check on a resident's needs. The SRNA reported LPN #2 would tell the staff not to get residents up to provide incontinent care, so she did not have to deal with them.

Interview with LPN #8, on 10/09/15 at 11:14 AM, revealed when LPN #2 goes into a resident's room to do a treatment, that she was "hateful with the residents" and "puts them down".

Interview with LPN #4, on 10/09/15 at 11:36 AM, revealed LPN #2 spoke harshly and rudely to residents, and reprimands them at times.

Interview with the DON, on 10/09/15 at 8:30 AM, revealed she was unaware of any verbal abuse of a resident by LPN #2. She did, however, mention that she spoke with LPN #2 about an incident. It was determined there was no abuse, and there was no disciplinary action taken.

Interview with the Administrator, on 10/07/15 at

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<p>F 241</p> <p>F 323</p> <p>SS=D</p>	<p>Continued From page 4</p> <p>1:35 PM, revealed LPN #2 attempted to educate the resident regarding the risks of Diabetes. There was no formal documentation regarding the event.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, the facility failed to ensure a safe environment for one (1) resident, in the selected sample of eight (8) residents (Resident #8), related to an unsecured, unlocked treatment cart containing medications.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure, "Medication Storage in the Facility", undated, revealed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.</p> <p>Record review revealed the facility admitted Resident #8 on 04/12/10 with diagnoses to include Sepsis, Chronic Airway Obstruction, Peripheral Vascular Disease (PVD), Diabetes,</p>	<p>F 241</p> <p>F 323</p>	<p>1. LPN#1 locked Treatment/medication cart upon interview with surveyor on 10/7/15.</p> <p>2. All other treatment/medication carts were checked on 10/7/15 and no other carts were found to be unlocked. The facility had random checks by both the Administrator and other department heads during the next week, but daily on October 12 through October 16. The administrator audited the nursing carts on 10/16/2015 and found the carts to be locked.</p> <p>3. Nurses and CMT's were educated by the Director of Nursing and Assistant Director of Nursing to ensure all treatment/medication carts are secured or locked when not attended on 10/08/2015. All newly hired CMT and Licensed nurses will be educated upon hire and the training will be repeated no less than annually.</p> <p>4. DON/ADON/Unit coordinators or designee will audit Treatment/medication carts daily for one week, weekly for 4 weeks, monthly for 4 months to ensure carts are secured or locked when not attended. Findings will be presented to QA committee monthly.</p> <p>5. Completion Date: November 13, 2015</p>

11/13/15

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F 323	<p>Continued From page 5</p> <p>and Lack of Coordination. Review of a quarterly Minimum Data Set (MDS) assessment, completed by the facility on 09/28/15, revealed the resident was assessed to have a Brief Interview Mental Status (BIMS) score of fifteen (15).</p> <p>Observation, on 10/07/15 at 9:50 AM, revealed an unattended, unlocked treatment cart, and Resident #8 sitting in a wheelchair beside the cart.</p> <p>Further observation revealed the facility has six (6) wanderers who were in close proximity of the unlocked treatment cart, prior to it being secured.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/07/15 at 9:55 AM, revealed she was in charge of the treatment cart and it should be locked at all times when not in attendance of authorized staff.</p> <p>Observation, on 10/08/15 at 8:35 AM, revealed an inventory of the treatment cart was completed by Registered Nurse (RN) #2. Observation revealed the treatment cart included the following medications or treatment items: Voltaren gel, muscle rub cream, Trolamine Salicylate, Mupircin Ointment, Nystatin, Triamcinolone, Estrace, Lidocaine Ointment, Trixaicin, Hydrocortisone cream, Preparation H Cream, Santyl, Silvadene, Compound W, Remedy Skin Care Cream, Sensi Care, Sensi Care 3, Critic Acid cream, Aloe Vesta, Magic Butt Cream, Hemorrhoidal pads, Hydrocerin, Miconazole, Aloe Vesta Skin Conditioning Lotion, Eucerin lotion, Remedy Cleansing body lotion, Rubbing Alcohol, Saf Clens AF wound cleanser, Hydrogen Peroxide, Adhesive remover, Skin prep, Heparin flush and</p>	F 323	

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F 323	Continued From page 6 Hemocull slide with developer. Interview with the Director of Nursing (DON), on 10/09/15 at 8:30 AM, revealed she expected treatment carts to be locked when not in direct attendance by a licensed staff. The potential hazard was medications kept in the cart which would be accessible to residents if the cart was not locked.	F 323		