

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

PRINTED: 08/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/17/2013
NAME OF PROVIDER OR SUPPLIER  GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE 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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1967</p> <p>SURVEY UNDER 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Four (4) stories, Type I (222)</p> <p>SMOKE COMPARTMENTS: Eleven (11) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Partial automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A Standard Life Safety Code Survey was conducted on 07/17/13. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred (100) beds with a census of eighty (80) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et. seq. (Life Safety from Fire)</p>		<p>POC ACCEPTED</p> <p>AUG 16 2013</p> 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Amanda Buckner* TITLE *Facility Director* (X6) DATE *8/14/13*

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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K 000	Continued From page 1  Deficiencies were cited with the highest Deficiency identified at "F" level.	K 000		
K 027 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1-3/4 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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of eighty (80) on the day of the survey. The facility failed to ensure doors located in a smoke barrier would resist the passage of smoke.</p> <p>The findings include:</p> <p>Observation, on 07/17/13 at 11:40 AM, with the Maintenance Manager, revealed the cross corridor doors in the smoke barriers located on the fourth floor had a gap greater than 1/8<sup>th</sup> of an</p>	K 027	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No residents were affected by the deficient practice.</p> <p>On July 18, 2013 the Mechanical Maintenance and Operations Manager adjusted the smoke barrier doors and closer along with latching hardware to ensure they resist the passage of smoke in accordance with NFPA standards.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents, staff and visitors have the potential to be affected.</p> <p>On July 18, 2013, the Mechanical Maintenance and Operations Manager inspected all cross corridor doors to ensure they resist the passage of smoke in accordance with NFPA standards. All were compliant.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>On August 06, 2013 the Maintenance staff was in-serviced per Mechanical Maintenance and Operations Manager as to proper closing of all smoke barriers and how to check if proper closing is accomplished per NFPA standards of a smoke barrier. All facility staff will be in-serviced by the Staff Development Coordinator/Mechanical Maintenance and Operations Managers by August 22, 2013, in accordance with NFPA standards of a smoke barrier and how doors would resist the passage of smoke to ensure the deficient practice will not reoccur. Any staff off on extended leave will be in-serviced on first day of return to work.</p>	8/22/13

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K 027	Continued From page 2  inch and would not resist the passage of smoke.  Interview on 07/17/13 at 11:40 AM, with the Maintenance Manager revealed he was not aware the door had a gap that was that large. He stated he would have the gaps adjusted to meet the requirement.  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.  Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18 mm) for wood doors.	K 027	An Inspection form was developed to check proper closure and integrity of the cross-corridor doors to ensure there are no gaps greater than 1/8 <sup>th</sup> of an inch. Inspections will be performed weekly by maintenance staff to ensure doors are in compliance until our move to new facility (anticipated date September 17, 2013) is completed. Thereafter, maintenance staff will complete a monthly inspection and audit using CQI Monitor ES-3 Life Safety. The Mechanical Maintenance and Operations Manager is responsible for reviewing the audit and ensuring any corrective action is completed. ES-3 was revised to reflect "The cross corridor doors do not have a gap more than 1/8" where the doors meet. There shall be no gap or a metal strip is installed to cover the gap."  Indicate how the facility plans to monitor its performance to ensure the solutions are sustained?  The findings of the monthly ES-3 Life Safety audit will be shared at the quarterly CQI Committee meeting. This committee is co-chaired by the facility superintendent associate.		
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	K 050	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice?  No residents were affected by the deficient practice.	8/22/13	

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K 050	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill record review, 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 eleven (11) of eleven (11) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of eighty (80) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times.</p> <p>The findings include:</p> <p>Review of the Fire Drill records, on 07/17/13 at 2:00 PM, with the Maintenance Manager revealed the facility failed to conduct fire drills at unexpected times on all three (3) shifts.</p> <p>Interview, on 07/17/13 at 2:00 PM, with the Maintenance Manager revealed he was not aware the fire drills were not being conducted as required.</p> <p>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.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire</p>	K 050	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>Upon assessment by the facility, it has been identified that all residents had the potential to have been affected if fire drills are not conducted at unexpected times on all three shifts.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>On August 05, 2013 the Mechanical Maintenance and Operations Manager revised Facility Policy "Fire Plan" to reflect that monthly fire drills on all three shifts are conducted at random, at varied times and at varied locations. Fire drills are tracked in a database by shift and time of drill. The location of the drill was added to the database on July 25, 2013. Documentation of the completed fire drills, including shift, time and location will be entered into the facility database.</p> <p>The Mechanical Maintenance and Operations Manager will conduct an in-service for staff assigned to conduct drills (maintenance and security staff) to be completed by August 22, 2013.</p>		

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K 050	Continued From page 4  Drills 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.  Review of fire drills will be added to the agenda for the monthly Fire & Safety Committee meeting. The year-to-date fire drill report will be printed and reviewed at the monthly meeting to ensure times and locations are varied. This committee is headed by the Safety Officer and members include the facility director and facility superintendent associate.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 076	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice?  No residents were affected by the deficient practice.  On August 9, 2013, the Mechanical Maintenance and Operations Manager separated the oxygen tanks as to whether they were full or empty. Full tanks were secured in one container and empty tanks in another container. A sign was posted above each container indicating whether it contained full or empty cylinders.	8/22/13

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K 076	<p>Continued From page 5 3,000 cu. ft. are enclosed by a one-hour separation.</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of eighty (80) on the day of the survey. The facility failed to ensure oxygen tanks were secured and signage was provided to indicate if the tanks were full or empty.</p> <p>The findings include:</p> <p>Observations, on 07/17/13 between 11:40 AM and 3:00 PM, with the Maintenance Manager revealed an oxygen tank sitting on the floor in the fourth (4<sup>th</sup>) floor oxygen room. The oxygen tank was not in a storage rack. Further observation revealed the oxygen tanks stored in the third (3<sup>rd</sup>) floor oxygen room did not have proper signage indicating if the tanks were full or empty.</p> <p>Interviews, on 07/17/13 between 11:40 AM and 3:00 PM, with the Maintenance Manager revealed</p>	K 076	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All resident have the potential to be affected. On August 9, 2013, facility policy "Oxygen Therapy and Oxygen Cylinder Storage" and the attached form "Oxygen Storage Record" were revised to reflect that cylinders cannot be stored on the floor. Empty and full cylinders must be separated and stored in separate containers. Each container was labeled with a sign reflecting whether the tanks were full or empty. The Oxygen Storage Record form is completed nightly by the 11/7 Charge Nurse. The completed Oxygen Storage Record forms will be sent to the Mechanical Maintenance and Operations Supervisor for review and correction of any issues identified.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Maintenance and nursing staff will be in-serviced on the Oxygen Therapy and Oxygen Cylinder Storage and Oxygen Storage Record by August 22, 2013. Any staff off on extended leave will be in-serviced on first day of return to work.</p> <p>Maintenance staff will complete a monthly inspection and audit using CQI Monitor ES-3 Life Safety. The Mechanical Maintenance and Operations Manager is responsible for reviewing the audit and ensuring any corrective action is completed. The form was revised to reflect that oxygen cylinders are stored in secure racks. Full and empty cylinders are stored separately and properly labeled "Full" and "Empty". No cylinders are stored on the floor.</p>	

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K 076	<p>Continued From page 5 3,000 cu. ft. are enclosed by a one-hour separation.</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of eighty (80) on the day of the survey. The facility failed to ensure oxygen tanks were secured and signage was provided to indicate if the tanks were full or empty.</p> <p>The findings include:</p> <p>Observations, on 07/17/13 between 11:40 AM and 3:00 PM, with the Maintenance Manager revealed an oxygen tank sitting on the floor in the fourth (4<sup>th</sup>) floor oxygen room. The oxygen tank was not in a storage rack. Further observation revealed the oxygen tanks stored in the third (3<sup>rd</sup>) floor oxygen room did not have proper signage indicating if the tanks were full or empty.</p> <p>Interviews, on 07/17/13 between 11:40 AM and 3:00 PM, with the Maintenance Manager revealed</p>	K 076	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All resident have the potential to be affected. On August 9, 2013, facility policy "Oxygen Therapy and Oxygen Cylinder Storage" and the attached form "Oxygen Storage Record" were revised to reflect that cylinders cannot be stored on the floor. Empty and full cylinders must be separated and stored in separate containers. Each container was labeled with a sign reflecting whether the tanks were full or empty. The Oxygen Storage Record form is completed nightly by the 11/7 Charge Nurse. The completed Oxygen Storage Record forms will be sent to the Mechanical Maintenance and Operations Supervisor for review and correction of any issues identified.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Maintenance and nursing staff will be in-serviced on the Oxygen Therapy and Oxygen Cylinder Storage and Oxygen Storage Record by August 15, 2013. Any staff off on extended leave will be in-serviced on first day of return to work.</p> <p>Maintenance staff will complete a monthly inspection and audit using CQI Monitor ES-3 Life Safety. The Mechanical Maintenance and Operations Manager is responsible for reviewing the audit and ensuring any corrective action is completed. The form was revised to reflect that oxygen cylinders are stored in secure racks. Full and empty cylinders are stored separately and properly labeled "Full" and "Empty". No cylinders are stored on the floor.</p>		

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K 076	<p>Continued From page 6</p> <p>he was not aware the tank on the fourth (4<sup>th</sup>) floor was not in the storage rack. Further interview revealed he was not aware empty and full tanks were to be separated and proper signage was required to indicate if the tanks were full or empty.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m<sup>3</sup> (300 ft<sup>3</sup>) but less than 85 m<sup>3</sup> (3000 ft<sup>3</sup>) (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) than can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall be separated from combustibles or materials by one of the follows: (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. (d) Liquefied gas container storage shall comply</p>	K 076	<p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>The findings of the monthly ES-3 Life Safety audit will be shared at the Quarterly CQI Committee meeting. This committee is co-chaired by the facility superintendent associate.</p>		

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K 076	Continued From page 7  with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b) 13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electrical heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft. (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.  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 147 SS=D	NFPA LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  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	K 147	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice?  No residents were affected by the deficient practice.	8/22/13	

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K 147	<p>Continued From page 8</p> <p>standards. The deficiency had the potential to affect two (2) of the eleven (11) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of eighty (80) on the day of the survey. The facility failed to maintain proper use of power strips.</p> <p>The findings include:</p> <p>Observations, on 07/17/2013 between 11:40 AM and 3:00 PM, with the Maintenance Manager revealed:</p> <ol style="list-style-type: none"> <li>1) A refrigerator was plugged into a power strip located in the Medicine Room on the fourth (4<sup>th</sup>) floor.</li> <li>2) A battery charger for battery operated lifts was plugged into a power strip located in room #423.</li> <li>3) A power strip was plugged into another power strip located in room #206.</li> </ol> <p>Interviews, on 07/17/13 between 11:40 AM and 3:00 PM, with the Maintenance Manager revealed he was unaware of the misuse of power strips.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number or receptacles shall be determined by the intended use of the patient care area. There shall</p>	K 147	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents and visitors have the potential to be affected. On July 17, 2013, the Mechanical Maintenance Operations Manager and the Facility Superintendent Associate inspected all areas of the facility for use of power strips. One power strip was found to be non-compliant and was removed.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Facility Policy SS - 707 Safe Physical Environment was revised to state that "Power strips are utilized in offices and only with equipment such as computers, monitors or printers and only after approval by the maintenance supervisor. Power strips may not be used with medical equipment, refrigerators or equipment that may have a power surge. A power strip cannot be plugged into another power strip." All facility staff will be in-serviced on Facility Policy SS-707 Safe Physical Environment by August 22, 2013. All staff on extended leave will be in-serviced upon first day of return to work.</p> <p>Monthly CQI Audit form ES-3 Life Safety was revised to read: "Power strips are utilized in offices and only with equipment such as computers, monitors or printers and only after approval by the maintenance supervisor. Power strips may not be used with medical equipment, refrigerators or equipment that may have a power surge. A power strip cannot be plugged into another power strip." The monthly ES-3 Life Safety audit is conducted by maintenance staff.</p>	

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 – MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  07/17/2013
NAME OF PROVIDER OR SUPPLIER  GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE 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 147	<p>Continued From page 9</p> <p>be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8 (Extension Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows or similar openings (4) Where attached to building surfaces</p>	K 147	<p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>Monthly ES-3 Life Safety inspections are reviewed by the Mechanical Maintenance and Operations Manager. This report is presented at the quarterly CQI meeting.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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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  07/19/2013
NAME OF PROVIDER OR SUPPLIER  GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 199 STATE AVENUE 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  A recertification survey was conducted on 07/17/13 through 07/19/13 to determine the facility's compliance with Federal requirements. The facility met the minimum health requirements for recertification with no regulatory violations identified.	F 000			

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

TITLE

(X6) 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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>100483</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/19/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GLASGOW STATE NURSING FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>199 STATE AVENUE GLASGOW, KY 42141</b>
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(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	<p><b>INITIAL COMMENTS</b></p> <p>A re-licensure survey was conducted on 07/17/13 through 07/19/13 to determine the facility's compliance with State requirements. The facility met the minimum health requirements for re-licensure with no regulatory violations identified.</p>	N 000		

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

TITLE

(X6) DATE