

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 07/13/2011
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NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141
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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED 2567</p> <p>An annual/extended survey was conducted 07/05/11 through 07/13/11. A Life Safety Code survey was conducted on 07/07/11. Immediate Jeopardy was determined to exist at 483.10 Resident Rights, F157; 483.25 Quality of Care, F323; and, 483.75 Administration, F490 related to the facility's failure to immediately notify the attending physician of the Resident #2's suicidal behaviors and failure to implement one to one supervision per the facility's policy and procedures. Substandard Quality of Care was identified at 483.25 Quality of Care. On 06/04/11, Resident #2 was found with the call light cord and oxygen tubing wrapped around his/her neck. The facility failed to immediately notify the resident's physician and failed to place Resident #2 on 1:1 supervision per policy. On 06/05/11, Resident #2 was again found with oxygen tubing wrapped around his/her neck and voiced suicidal ideations. The resident's physician was not notified of the resident's second attempt to harm self. After the incidents, the facility immediately developed and implemented interventions for Resident #2 on 06/04/11, 06/05/11, 06/06/11 and 06/09/11 to correct the deficiencies. Immediate Jeopardy was determined to exist on 06/04/11 through 06/09/11. It was determined the facility had completed all corrective action prior to the State Agency initiating the annual survey, thus resulting in the determination of Past Jeopardy. The Jeopardy was determined to be corrected on 06/10/11.</p> <p>The facility failed to meet minimum requirements based on the annual survey and Life Safety Code</p>	F 000	<p>F000</p> <p>DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES AND DISPUTES THE DEFICIENCIES STATED IN THE 2567. FURTHER, THE FACILITY DISPUTES AND DISAGREES WITH THE ACCURACY OF STATEMENTS AND OTHER INFORMATION RELIED UPON IN THE 2567 IN SUPPORT OF THE DEFICIENCIES. THIS INCLUDES, BUT IS NOT LIMITED TO, THE ALLEGED CONTENT/SUMMARY OF MULTIPLE INTERVIEWS, THE CHRONOLOGICAL/TIMING SEQUENCE OF EVENTS AND TIMELINESS OF CONTACT WITH HEALTH CARE PROFESSIONALS AND THE CARE AND SUPERVISION PROVIDED TO THE RESIDENTS. THE FACILITY PRESENTED CONTRARY EVIDENCE DURING THE SURVEY ITSELF AND IN THE DISPUTE RESOLUTION MEETING.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Yvonne W. Cook</i>	TITLE Administrator	(X6) DATE 9/23/2011
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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 000	Continued From page 1 survey with the highest scope and severity of a "F".	F 000		
F 157 SS=J	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 157		

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F 157	<p>Continued From page 2</p> <p>by:</p> <p>Based on interview, record review, and review of facility policies, it was determined the facility failed to have an effective system to ensure the resident's physician was immediately consulted for one resident (#2), in the selected sample of fifteen residents, who displayed suicidal behaviors and voiced suicidal ideations.</p> <p>On 06/04/11 at 6:40 AM, facility staff found Resident #2, in his/her room, with a call light cord and oxygen (O2) tubing tangled and wrapped around the resident's neck. The facility failed to implement the one-to-one supervision and notification of the physician, per facility policy and procedure. On 06/05/11 at 8:30 AM, approximately 26 hours after the first episode, while in his/her room, facility discovered Resident #2 with O2 tubing wrapped around his/her neck. The resident told staff that if they did not kill him/her, he/she would kill him/herself. The facility failed again to implement one-to-one supervision and notify the resident's physician, per the facility policy and procedure, after the second incident.</p> <p>The facility's failure to notify and/or consult with the physician resulted in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist, on 06/04/11 through 06/09/11. The facility implemented corrective action which was completed prior to the State Agency's standard survey, thus it was determined Past Jeopardy. The Jeopardy was determined to be corrected on 06/10/11.</p> <p>The findings include:</p>	F 157	Past noncompliance: no plan of correction required.	

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F 157	<p>Continued From page 3</p> <p>A review of the facility's policy entitled, "Notifying Physician of Change in Resident Condition," dated 01/28/07, revealed the facility would keep the attending physician updated on the resident's condition. A change in condition would be assessed by a licensed nurse and reported to the attending physician. The nurse would utilize his/her judgement to determine the need for physician notification. Procedures included to notify the attending physician, and if the attending physician was unavailable, the on-call physician would be called, and then the medical director.</p> <p>A review of the facility's policy entitled, "Suicide Precaution," undated, revealed the facility would attempt to protect residents from acts of self harm, when suicidal ideations were voiced. Procedures included to assign employee to sit with resident one-to-one, while notifying physician of resident's threats to harm self; and to notify the Director of Nursing (DON) of threats to harm self.</p> <p>Record review revealed Resident #2 was admitted to the facility, on 04/29/11, with diagnoses to include Nonorganic Psychosis. Review of the resident's admission Minimum Data Set (MDS) assessment, completed on 05/09/11, revealed the facility assessed the resident to be moderately impaired in cognition. The facility assessed the resident to exhibit behaviors of restlessness, insomnia, and to resist care.</p> <p>A review of nurses notes, dated 06/04/11 at 6:40 AM, revealed Certified Medication Technician (CMT) #1 found Resident #2 in bed, with the oxygen (O2) tubing and call light cord tangled together and wrapped around his/her neck.</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>CMT#1 removed the tubing and call light cord from around the resident's neck and the resident was brought to the dining room, in a wheelchair.</p> <p>An interview with CMT #1, on 07/07/11 at 1:50 PM, revealed she discovered Resident #2 in the resident's room, on 06/04/11 at 6:40 AM. CMT #1 stated the resident had the call light and O2 tubing wrapped around his/her neck, at least eight times. She revealed she attempted to calm the resident; however, all the resident would say was, "Praise the Lord and I love Jesus." CMT #1 stated she removed the call light from the room, removed the O2 tubing from the resident's neck, and notified Licensed Practical Nurse (LPN) #1.</p> <p>An interview with LPN #1, on 07/07/11 at 3:00 PM, revealed she completed the documentation, dated 06/04/11 at 6:40 AM. LPN #1 revealed she did not contact the physician, because it was the change of shift and the on-coming nurse told her, she would contact the physician. She revealed the resident was brought to the dining room; however, no staff member was assigned to provide one-to-one supervision for Resident #2.</p> <p>A review of nurses notes, dated 06/04/11 at 7:45 AM, revealed the facility initiated "suicidal precautions", due to the resident's behavior. Further review of the nurses notes revealed the suicidal precautions included the call light cords were removed from the resident's room, and the resident and his/her room mate were provided call bells. The staff was notified of the suicide precautions. Further review revealed no evidence the resident's physician was notified of the resident's behavior of self harm.</p>	F 157		

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F 157	<p>Continued From page 5</p> <p>An interview with Registered Nurse (RN) #1, on 07/07/11 at 9:25 AM, revealed she completed the documentation, dated 06/04/11 at 7:45 AM. RN #1 revealed she notified the Advanced Registered Nurse Practitioner (ARNP), but did not notify the physician. She obtained an order from the ARNP for "suicidal precautions", which included call light cords were removed from the resident's room, and the resident and his/her room mate were provided call bells. She stated Resident #2 remained in the dining room, however, no staff were assigned to provide one-to-one supervision.</p> <p>A review of nurse's notes, dated 06/05/11 at 8:30 AM, revealed staff again observed Resident #2, with O2 tubing wrapped around his/her neck. Resident #2 stated, the gas was going to kill him/her and if, "you don't kill me, I'll kill myself". There was no documented evidence the facility notified the primary physician, regarding Resident#2's continued suicidal behaviors and expressions of intent to kill him/herself.</p> <p>An interview with LPN #2, on 07/07/11 at 3:30 PM, revealed she completed the nurse's note, dated 06/05/11 at 8:30 AM. She revealed the resident wrapped the O2 tubing around his/her neck and stated, "if we didn't kill him/her then he/she was going to kill him/herself." LPN #2 stated she notified the ARNP; however, she did not receive a returned call from the ARNP, until 11:10 AM, two hours and 40 minutes, after the incident. She revealed she did not attempt to notify the resident's primary physician or on-call physician in the interim, and did not attempt to call the ARNP again, when she did not get a response.</p>	F 157		

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F 157	<p>Continued From page 6</p> <p>An interview with the ARNP, on 07/08/11 at 9:00 AM, revealed she did not recall the 06/04/11 incident, but did recall the 06/05/11 incident. She revealed a nurse called her on 06/05/11; however, if the call was placed at 8:30 AM, she probably did not call back till 11:10 AM, because she would not have returned home from church, until that time. She revealed she was unaware Resident #2's had made a statement, on 06/05/11, that if the facility staff would not kill him/her then he/she would kill him/herself. The ARNP revealed she would have expected the facility to notify the on-call physician at the time the resident made the statement. She revealed when she returned the call at 11:10 AM, she instructed the staff to keep the resident near the nurse's station area, because she could not discontinue the oxygen because the resident needed the treatment, due to Pneumonia.</p> <p>An interview with Resident #2's primary physician, on 07/08/11 at 10:50 AM, revealed he was unaware of either incident, on 06/04/11 or 06/05/11, when Resident #2 exhibited suicidal behaviors and expressed suicidal thoughts. The resident's physician revealed he would have expected the facility to notify either himself or the on-call physician of such behaviors, and have the resident sent out of the facility for a psychiatric evaluation. He also revealed he was the on-call physician, on 06/04/11 at 6:40 AM, and did not recall receiving a call from the facility, regarding Resident #2.</p> <p>Interviews with the DON, on 07/08/11 at 12:00 PM and 2:25 PM, revealed she was not notified of Resident #2's behaviors, until 06/05/11, when</p>	F 157		

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F 157	<p>Continued From page 7</p> <p>RN #1 notified her after the second incident. She stated she expected staff to notify the physician as soon as the resident was safe. She stated LPN #1 should have contacted the physician on 06/04/11 after the first incident.</p> <p>An interview with the Administrator, on 07/13/11 at 4:40 PM, revealed she would expect staff to "secure" the resident and contact the physician for instructions.</p> <p>The facility implemented the following actions to correct the deficiency:</p> <ul style="list-style-type: none"> -On 06/04/11, the facility initiated suicide precautions. Resident #2's call light was removed, as well as the resident's roommate's call light, on 06/04/11, and both residents were provided a call bell. -On 06/04/11 Resident #2's care plan was updated to include suicide precautions. -Inserviced all licensed staff, on 06/06/11, on suicidal precautions, to include assigning staff to remain with resident on a one to one basis and notifying the resident's attending physician concerning the resident's behavior. <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>An observation of Resident #2's room, on 07/05/11 at 12:45 PM, revealed a call bell in place and the call light removed from the room.</p> <p>Observations of Resident #2, on 07/05/11 at 3:30 PM, 07/06/11 at 8:20 AM, 07/06/11 at 9:00 AM</p>	F 157		

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F 157	<p>Continued From page 8 and 07/06/11 at 11:00 AM. revealed Resident #2 up in either the dining room or lobby area. Resident's affect was bright and made good eye contact when approached. Resident engaged in activities on 07/05/11 at 3:00 PM and 07/06/11 at 11:00 AM.</p> <p>Interviews with the DON, on 07/08/11 at 12:00 PM and 07/13/11 at 4:35 PM, revealed she had inserviced licensed staff on 06/06/11 regarding the care of a resident threatening to harm him/herself. The DON stated the purpose of the inservice was to review with the licensed staff what to do when a resident was exhibiting self harm behaviors or threats to someone else.</p> <p>A review of the facility's inservice training report, dated 06/06/11, revealed licensed nurses were inserviced regarding what to do when a resident threatens to harm themselves. Training record indicated staff was to maintain one to one supervision until safety is maintained and to notify the physician for instructions. A review of the signature portion of the training record revealed all licensed staff had signed as having received the training.</p> <p>Interviews with RN #1 and LPN #4, on 07/08/11 at 2:10 PM and 9:45 AM, respectively, revealed both licensed staff had been provided an inservice on suicide precautions, on 06/06/11, by the DON. Both related knowledge of the inservice to include placing the resident on one to one supervision to ensure safety, contacting the physician to report the resident's behavior, encourage transfer out of the facility for a psychiatric evaluation and initiate safety checks as directed by the physician.</p>	F 157		

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F 157	<p>Continued From page 9</p> <p>Interviews with certified medication technicians (CMT) #1 and #2, on 07/08/11 at 9:30 AM and 10:20 AM, revealed both CMTs were aware of the facility policy on suicidal precautions and how to respond when a resident displayed suicidal behavior or expressed suicidal thoughts. These interventions included to monitor the resident to ensure safety, report the behavior to the licensed staff immediately, remove all harmful items from the resident's room including the call light and to initiate safety checks as directed by the licensed staff.</p> <p>Interviews with certified nurse aids (CNA) #1, #2, #3, #4 and #5, on 07/08/11 at 10:30 AM, 9:45 AM, 9:55 AM, 10:05 AM and 10:10 AM, respectively, revealed all the CNAs aware of the facility policy on suicidal precautions and how to respond when a resident displayed suicidal behavior or expressed suicidal thoughts. These interventions included to monitor the resident to ensure safety, report the behavior to the licensed staff immediately, remove all harmful items from the resident's room including the call light and to initiate safety checks as directed by the licensed staff.</p>	F 157		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide or arrange</p>	F 281		

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F 281	<p>Continued From page 10</p> <p>services to meet professional standards of quality for one resident (#3), in the selected sample of fifteen (15), related to failure to follow a physician's order for a wound treatment. Physician's orders were inaccurately transcribed following Resident #3's visit to the Wound Care Center on 07/01/11.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure titled "Procedure for Taking off New Physician's Orders," undated, revealed "to place on Medication Administration Record (MAR) and TAR, as appropriate."</p> <p>A record review revealed Resident #3 was admitted to the facility on 03/18/10 with diagnoses to include Chronic Stage IV Sacral Ulcer, Hemiplegia with left sided weakness, Cerebrovascular Accident, Renal Failure, Anxiety, Acute Pain related to Stage IV Sacral Ulcer, Parkinson's, History of Chronic Urinary Tract Infections, Pseudomonas Colonized Urine, Arthritis, Hypertension, History of Pneumonia, Gastroenteritis, Anemia, History of Coronary Artery Bypass Graft, Cardiomyopathy, Atrial Fibrillation, History of Fractured Femur with Open Reduction Internal Fixation left hip, Cardiac Pacemaker and Diabetes Mellitus Type II.</p> <p>Further record review revealed Resident #3 returned from the Wound Care Clinic, on 07/01/11, with treatment orders for a stage IV pressure ulcer on his/her coccyx. A review of the orders, dated 07/01/11, revealed "cleanse the ulcer site with normal saline and pat dry. Gently place 1/4 strength Dakin's solution moistened</p>	F 281	<p>F281 283.20 (K) (3) (I)</p> <ol style="list-style-type: none"> On 7/07/2011 LPN clarified order from wound center in regard to the treatment of resident #3's wound. Order reads as follows: Cleanse coccyx ulcer with normal saline and pat dry. Gently place moistened gauze with 1/4 strength Dakin's solution and pack into ulcer. Cover with ABD pad and secure with medipore tape after applying skin barrier to the peri-ulcer skin BID. Apply Critic Aid and Nystation Cream 1:1 mixture to the peri-ulcer skin BID. On 7/08/2011 one-on-one teaching moment given by DON to LPN #4 regarding proper procedure for measuring wound depth. On 7/29/2011 ADON audited the treatment records of all residents to ensure that wound treatment records were properly transcribed from the physician orders. All MD orders were found to be correctly transcribed and recorded on MAR's and TAR's. On 7/27, 7/28, and 7/29 the QA nurse reviewed all MD orders and ensured that all MD orders were properly transcribed onto the MAR's and TAR's. 	

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F 281	<p>Continued From page 11</p> <p>gauze into the coccyx ulcer and change the dressing two times a day. Cover with an ABD pad and secure with medipore tape after applying skin barrier to the peri-ulcer skin. Ensure the dressing is secured on all sides. Apply Critic-Aid and Nystatin Cream 1:1 mixture to the peri-ulcer skin two times a day."</p> <p>A review of the treatment administration record (TAR), dated 07/11, revealed "Dakin's solution, cleanse the wound with normal saline and apply a wet to moist dressing." The 07/01/11 order was transcribed incorrectly.</p> <p>An observation during a treatment, on 07/06/11 at 10:25 AM, revealed Licensed Practical Nurse (LPN) #2 did not cleanse the wound with normal saline solution as ordered. LPN #2 applied Dakin's solution to the gauze and used cotton tipped applicator to pack the wound. She applied Nystatin cream and Critic-Aid to the surrounding tissue and covered it with gauze and medipore tape. An interview with LPN #2, at 10:45 AM, revealed she did not usually use the normal saline solution and only used it to cleanse the area, if the area was soiled.</p> <p>Further observation during a treatment, on 07/08/11 at 11:30 AM, revealed LPN #4 applied normal saline solution to the gauze and cleansed the wound. She then inserted a cotton tipped applicator into the wound for wound measurements and used a marker to mark the applicator, while it was still in the wound and returned the marker to her pocket. LPN #4 applied Dakin's solution to the gauze and packed the wound, and then covered the wound with 2x2 gauze and applied the medipore tape. No skin</p>	F 281	<p>F281 (cont.)</p> <p>3. On 7/26/2011 DON in-serviced all licensed nurses regarding transcription of all MD orders onto the MAR's, TAR's and labs. If changes are needed the nurse must obtain clarification from MD order.</p> <ul style="list-style-type: none"> A. Licensed nurse will receive MD order and transcribe order onto MAR's and TAR's. B. Quality Assurance Nurse will verify all MD orders have been transcribed onto MAR's and TAR's accurately on a weekly basis. QA nurse will obtain clarification on orders if necessary. C. QA nurse will report to DON on a weekly basis regarding weekly findings. <p>4. DON will report verification finding to the Administrator on a monthly basis. Administrator will report findings to the QA committee monthly for one year.</p>	7/30/2011

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F 281	Continued From page 12 barrier cream, Critic-Aid or Nystatin cream was applied. An interview with the Director of Nursing (DON), on 07/06/11 at 12:50 PM, revealed Resident #3's wound treatment orders, dated 07/01/11, were transcribed to the TAR incorrectly. The orders and the TAR did not match. She stated she expected the nurses to transcribe orders correctly and carry out the treatments correctly, and she revealed Resident #3's treatment was not completed as ordered. If orders were unclear, the nurses were to clarify the information.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure one resident (#1), in the selected sample of fifteen (15), received the appropriate treatment and services to prevent urinary tract infections. The findings include:	F 315	F315 483.25 (D) 1. On 7/07/2011 CNA #10 secured and positioned the catheter tubing off the floor and the drainage bag was replaced in a dignity bag for resident #1. 2. On 7/07/2011 LPN #4 and CMT #1 performed sweep of building to assure that all tubing and catheters were off the floor and secure in dignity bags. 3. On 7/10/2011 DON in-serviced all nursing staff with regard to policy and procedure NP-00070 Foley Catheter insertion-Maintenance-Removal and policy and procedure for Closed Urinary Drainage.	/

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F 315	<p>Continued From page 13</p> <p>A review of the facility's policy and procedure for "Foley Catheter Insertion-Maintenance-Removal," undated, revealed "Secure catheter to thigh and attach to drainage bag."</p> <p>A record review revealed Resident #1 was admitted to the facility on 08/31/10 with diagnoses to include Dementia, Osteoarthritis, Renal Failure and Neuropathy.</p> <p>An observation, on 07/07/11 at 9:32 AM, revealed Resident #1 was being assisted by CNA #10 while in his/her geri-chair in the hallway. The resident's catheter bag was dragging on the floor and the catheter tubing was behind the wheel of the geri-chair. Resident #1 was sitting in the geri-chair with a leg strap lying on his/her lap and the catheter was not secured at this time.</p> <p>An interview with CNA #10, on 07/07/11 at 9:55 AM, revealed the catheter should be secured and the catheter tubing should not drag on the floor.</p> <p>An interview with the DON, on 07/07/11 at 2:15 PM, revealed the drainage bag should be in a dignity bag and the catheter tubing should not drag on the floor. The DON stated when the residents were provided showers, the staff usually took the leg bands off; however, the staff was to ensure the leg bands were placed back on the resident once the shower was completed. The DON revealed she expected the nursing staff to monitor proper placement of the leg bands.</p>	F 315	<p>F315 (cont.)</p> <p>4. Licensed nurses will monitor catheters per shift on all resident treatment records. The management team will perform weekly dignity/infection control audit and give to Administrator for review during monthly QA for one year.</p>	7/30/2011
F 323 SS=J	<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</p>	F 323		

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F 323	<p>Continued From page 14</p> <p>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 interview, record review, and review of facility policies, it was determined the facility failed to have an effective system in place to ensure adequate supervision was provided for one resident (Resident #2), in the selected sample of fifteen (15) residents, when the resident exhibited suicidal behavior and expressed intent to "kill" him/herself. The facility failed to implement established policy and procedures related to one-to-one supervision.</p> <p>On 06/04/11 at 6:40 AM, facility staff found Resident #2, in his/her room, with a call light cord and oxygen (O2) tubing tangled and wrapped around the resident's neck. The facility failed to implement the one-to-one supervision and notification of the physician, per facility policy and procedure.</p> <p>On 06/05/11 at 8:30 AM, approximately 26 hours after the first episode, while in his/her room, facility staff discovered Resident #2 with O2 tubing wrapped around his/her neck. The resident told staff that if they did not kill him/her, he/she would kill him/herself. The facility failed to implement the one-to-one supervision and notification of the physician, per the facility policy and procedure, after the second incident.</p>	F 323	Past noncompliance: no plan of correction required.	

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F 323	<p>Continued From page 15</p> <p>The facility's failure to implement one-to-one supervision resulted in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist, on 06/04/11 through 06/09/11. The facility implemented corrective action which was completed prior to the State Agency's standard survey, thus it was determined Past Jeopardy. The Jeopardy was determined to be corrected on 06/10/11.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled, "Suicide Precaution", undated, revealed the facility would attempt to protect residents from acts of self harm, when suicidal ideations were voiced. Procedures included to assign employee to sit with resident one-to-one, while notifying physician of resident's threats to harm self; to notify physician of threats to harm self and encourage transfer to another facility for evaluation; to notify the Director of Nursing (DON) of threats to harm self; to initiate safety checks to monitor resident closely for further threats to harm self; and, to schedule psychiatrist evaluation.</p> <p>Record review revealed Resident #2 was admitted to the facility, on 04/29/11, with diagnoses to include Nonorganic Psychosis and Chronic Renal Failure. Review of the resident's admission Minimum Data Set (MDS) assessment, completed on 05/09/11, revealed the facility assessed the resident to be moderately impaired in cognition. The facility assessed the resident to exhibit behaviors of restlessness, insomnia, and to resist care.</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>Review of the resident's comprehensive plan of care, dated 05/09/11, revealed interventions which included to check on the resident every 1-2 hours and when passing for needs and safety, and to consult with the facility's Psychiatrist as needed.</p> <p>An interview, on 07/07/11 at 1:50 PM, with CMT #1, revealed she discovered Resident #2 in the resident's room, on 06/04/11 at 6:40 AM. CMT #1 stated the resident had the call light cord and O2 tubing wrapped around his/her neck, at least eight times. She attempted to calm the resident; however, all the resident said was, "Praise the Lord and I love Jesus." CMT #1 stated she removed the call light from the room, removed the O2 tubing from the resident's neck, and notified the nurse.</p> <p>An interview, on 07/07/11 at 3:00 PM, with Licensed Practical Nurse (LPN) #1, revealed the resident was brought to the dining room after the incident on 06/04/11; however, no staff member was assigned to provide one-to-one supervision for Resident #2.</p> <p>A review of nurses notes, dated 06/04/11 at 6:40 AM and completed by LPN #1, revealed Certified Medication Technician (CMT) #1 found Resident #2 in bed, with the oxygen (O2) tubing and call light cord tangled together and wrapped around his/her neck. CMT#1 removed the tubing and call light cord from around the resident's neck and the resident was assisted to the dining room in a wheelchair. The documentation revealed the intervention implemented was to continue to "monitor" the resident.</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>A review of nurses notes, dated 06/04/11 at 7:45 AM, revealed the facility initiated "suicidal precautions", due to the resident's behavior. Further review of the nurses notes revealed the suicidal precautions included the call light cords were removed from the resident's room, and the resident and his/her room mate were provided call bells.</p> <p>An interview with Registered Nurse (RN) #1, on 07/07/11 at 9:25 AM, revealed she completed the documentation, dated 06/04/11 at 7:45 AM. RN #1 revealed she notified the Advanced Registered Nurse Practitioner (ARNP), but did not notify the physician. She obtained an order from the ARNP for "suicidal precautions", which included call light cords were removed from the resident's room, and the resident and his/her room mate were provided call bells. The staff was notified of the suicide precautions. She stated Resident #2 remained in the dining room; however, no staff were assigned to provide one-to-one supervision.</p> <p>A review of nurse's notes, dated 06/05/11 at 8:30 AM, revealed staff again observed Resident #2, with O2 tubing wrapped around his/her neck. Resident #2 told staff if, "you don't kill me, I'll kill myself". The resident remained on suicidal precautions. Further review of the clinical record revealed no documented evidence staff had evaluated the residents self harming behaviors and/or implemented or modified interventions to ensure the resident's safety.</p> <p>An interview with LPN #2, on 07/07/11 at 3:30 PM, revealed she completed the nurse's note documentation, dated 06/05/11 at 8:30 AM. She</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>revealed the resident wrapped the O2 tubing around his/her neck and stated, "if we didn't kill him/her then he/she was going to kill him/herself." LPN #2 stated she guessed the facility should have placed the resident on one-to-one supervision. She stated, by having the resident near the nursing station, she felt the resident was within sight of staff.</p> <p>An interview, on 07/08/11 at 9:00 AM, with the ARNP, revealed she did not recall the 06/04/11 incident, but did recall the 06/05/11 incident. She revealed she was unaware Resident #2 had the statement of intent to kill his/herself, if staff did not kill him/her, on 06/05/11. The ARNP revealed she would have expected the facility to notify the on-call physician at the time the resident made the statement.</p> <p>An interview with Resident #2's primary physician, on 07/08/11 at 10:50 AM, revealed he was unaware of either incident, on 06/04/11 or 06/05/11, when Resident #2 exhibited suicidal behaviors and expressed suicidal thoughts. The resident's physician revealed he would have expected the facility to notify either himself or the on-call physician of such behaviors, and have the resident sent out of the facility for a psychiatric evaluation. He also revealed he was the on-call physician, on 06/04/11 at 6:40 AM, and did not remember receiving a call from the facility, regarding Resident #2.</p> <p>Interviews with the DON, on 07/08/11 at 12:00 PM and 2:25 PM, revealed she became aware of Resident #2's behaviors, on 06/05/11, when RN #1 notified her of the second incident. She stated she expected staff to place a resident displaying</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>suicidal behaviors or voicing suicidal thoughts on one-to-one supervision to ensure the resident's safety, and notify the physician as soon as the resident was safe.</p> <p>Further interview with the DON, on 07/08/11 at 2:40 PM, revealed she expected the nurses to document at least every shift on residents with suicide precautions. Per interview the nurses should assess how the resident was doing, if any thoughts of self harm were voiced, or if any self harm behaviors were exhibited.</p> <p>An interview with LPN #2 on 07/07/11 at 3:30 PM revealed she "guessed" the resident should have been charted on every shift due to suicide precautions; however, this was not done. An interview with RN #1 on 07/08/11 at 2:10 PM revealed the resident's mental status and thoughts of self harm should "probably" be monitored every hour when on suicide precautions. Further interview revealed she did not implemented this for Resident #2.</p> <p>An interview with the Administrator, on 07/13/11 at 4:40 PM, revealed she would expect staff to "secure" the resident while contacting the physician for instruction. She stated securing the resident would mean staying with the resident or at least doing "tag teams" on the resident. First we would contact the doctor and follow his or her instructions.</p> <p>The facility implemented the following actions to correct the deficiency:</p> <p>-On 06/04/11, the facility initiated suicide precautions. Resident #2's call light was</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>removed, as well as the resident's roommate's call light, on 06/04/11, and both residents were provided a call bell.</p> <p>-On 06/04/11 Resident #2's care plan was updated to include suicide precautions.</p> <p>-Obtained an order, on 06/05/11, for a urinalysis with culture and sensitivity due to increased confusion, agitation and change in behavior.</p> <p>-Obtained an order, on 06/06/11, to begin Ativan 0.5 milligrams (mg) three times a day.</p> <p>-Conducted a care plan meeting with Resident #2's family, on 06/06/11, to discuss resident's situation. Allowed family to bring in sewing machine, to assist resident with adjustment issues, at the family's request. Changed Resident #2's room, at the family's request.</p> <p>-Inserviced all licensed staff, on 06/05/11, on suicidal precautions, to include assigning staff to remain with resident on a one to one basis and notifying the resident's attending physician concerning the resident's behavior.</p> <p>-Provided psychiatric services for Resident #2, on 06/09/11, and implemented psychiatrist's recommendations of trial of the antidepressant Citalopram and to engage the resident's socialization activities.</p> <p>-Obtained an order, dated 06/09/11 at 10:50 AM, to begin Citalopram 20 mg. every day.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>An observation of Resident #2's room, on 07/05/11 at 12:45 PM, revealed a call bell in place and the call light removed from the room.</p> <p>Observations of Resident #2, on 07/05/11 at 3:30 PM, 07/06/11 at 8:20 AM, 07/06/11 at 9:00 AM and 07/06/11 at 11:00 AM, revealed Resident #2 up in either the dining room or lobby area. Resident's affect was bright and made good eye contact when approached. Resident engaged in activities on 07/05/11 at 3:00 PM and 07/06/11 at 11:00 AM.</p> <p>A record review of Resident #2's current physicians orders revealed the resident remained on Citalopram 20 mg. every day and Ativan 0.5 mg three times a day.</p> <p>Interviews with the DON, on 07/08/11 at 12:00 PM and 07/13/11 at 4:35 PM, revealed she had inserviced licensed staff on 06/06/11 regarding the care of a resident threatening to harm him/herself. The DON stated the purpose of the inservice was to review with the licensed staff what to do when a resident was exhibiting self harm behaviors or threats to someone else.</p> <p>A review of the facility's inservice training report, dated 06/06/11, revealed licensed nurses were inserviced regarding what to do when a resident threatens to harm themselves. Training record indicated staff was to maintain one to one supervision until safety is maintained and to notify the physician for instructions. A review of the signature portion of the training record revealed all licensed staff had signed as having received the training.</p>	F 323		

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F 323	<p>Continued From page 22</p> <p>An interview with the social services director, on 07/08/11 at 11:15 AM, revealed she had met with Resident #2's family on 06/06/11 to discuss resident's behavior. Family requested a room change and to be allowed to bring in a sewing machine to help resident with adjustment issues. She stated room was changed on 06/06/11 and family brought sewing machine to the facility. Family did not want resident sent out of facility for a psychiatric evaluation as did not feel resident was suicidal but was having difficulty adjusting to being at the facility.</p> <p>An interview with Resident #2's daughter, on 07/08/11 at 11:25 AM, revealed the facility had contacted her regarding the resident's behavior. She stated did not feel resident's behavior was suicidal, but rather was related to adjustment issues. Daughter revealed she had told facility she did not want resident sent out of the facility for a psychiatric evaluation. The facility also adjusted the resident's medications and allowed the daughter to bring in a sewing machine, which she had brought to the facility on 06/06/11.</p> <p>Interviews with certified medication technicians (CMT) #1 and #2, on 07/08/11 at 9:30 AM and 10:20 AM, revealed both CMTs were aware of the facility policy on suicidal precautions and how to respond when a resident displayed suicidal behavior or expressed suicidal thoughts. These interventions included to monitor the resident to ensure safety, report the behavior to the licensed staff immediately, remove all harmful items from the resident's room including the call light and to initiate safety checks as directed by the licensed staff.</p>	F 323		

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F 323	Continued From page 23 Interviews with certified nurse aids (CNA) #1, #2, #3, #4 and #5, on 07/08/11 at 10:30 AM, 9:45 AM, 9:55 AM, 10:05 AM and 10:10 AM, respectively, revealed all the CNAs aware of the facility policy on suicidal precautions and how to respond when a resident displayed suicidal behavior or expressed suicidal thoughts. These interventions included to monitor the resident to ensure safety, report the behavior to the licensed staff immediately, remove all harmful items from the resident's room including the call light and to initiate safety checks as directed by the licensed staff. Interviews with RN #1 and LPN #4, on 07/08/11 at 2:10 PM and 9:45 AM, respectively, revealed both licensed staff had been provided an inservice on suicide precautions, on 06/06/11, by the DON. Both related knowledge of the inservice to include placing the resident on one to one supervision to ensure safety, contacting the physician to report the resident's behavior, encourage transfer out of the facility for a psychiatric evaluation and initiate safety checks as directed by the physician.	F 323		
F 490 SS-J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 490		

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F 490	<p>Continued From page 24</p> <p>by:</p> <p>Based on interview, record review, and review of facility policies, it was determined the facility failed to have an effective system in place to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility failed to have an effective system to ensure implementation of their policy pertaining to suicidal precautions and for physician notification for one resident (#2), in the selected sample of fifteen residents.</p> <p>On 06/04/11 at 6:40 AM, facility staff found Resident #2, in his/her room, with a call light cord and oxygen (O2) tubing tangled and wrapped around the resident's neck. The facility failed to implement the one-to-one supervision and notification of the physician, per facility policy and procedure.</p> <p>On 06/05/11 at 8:30 AM, within 26 hours of the first episode, facility staff discovered Resident #2 with O2 tubing wrapped around his/her neck. The resident told staff that if they did not kill him/her, he/she would kill him/herself. The facility failed to implement the one-to-one supervision and notification of the physician, per the facility policy and procedure, after the second incident.</p> <p>The facility's failure to ensure Resident #2 received the appropriate level of supervision directed by the facility policy, resulted in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist, on 06/04/11 through</p>	F 490	Past noncompliance: no plan of correction required.	

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F 490	<p>Continued From page 25</p> <p>06/09/11. The facility implemented corrective action which was completed prior to the State Agency's standard survey, thus it was determined Past Jeopardy. The Jeopardy was determined to be corrected on 06/10/11.</p> <p>The findings include: Reference to F157 and F323.</p> <p>The facility failed to ensure Resident #2 received adequate supervision to prevent an accident (suicide) and failed to ensure the resident's physician was notified and provided sufficient information regarding the resident suicidal behavior and suicidal expressions, in accordance with facility policy and procedure. On 06/04/11 at 6:40 AM, Resident #2 was observed with the call light and oxygen tubing wrapped around his/her neck. The facility implemented suicide precautions on the resident; however, failed to implement one-to-one supervision and failed to notify the resident's physician. On 06/05/11 at 8:30 AM, while on suicide precautions, Resident #2 was again observed with oxygen tubing wrapped around his/her neck and the resident stated, "if you won't kill me I will kill myself." The facility failed to place Resident #2 on one-to-one supervision and/or contact the attending or the on-call physician, after the second incident. Instead, staff notified the Advanced Registered Nurse Practitioner (ARNP) and left a message, which was not addressed with a return call for two hours and forty minutes. In the interim, Resident #2 was not provided one-to-one supervision and licensed staff made no attempt to contact the on-call physician.</p>	F 490		

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F 490	<p>Continued From page 26</p> <p>The Director of Nursing (DON) was notified of Resident #2's behaviors and suicidal threats, on 06/05/11, after the second incident, and provided no additional guidance to staff at the time.</p> <p>Interviews with the DON, on 07/08/11 at 12:00 PM, on 07/13/11 at 4:35 PM, and on 07/08/11 at 2:40 PM revealed she expected staff to place a resident displaying suicidal behaviors or voicing suicidal thoughts on one-to-one supervision to ensure the resident's safety, and notify the physician as soon as the resident was safe. Per interview the nurses should assess how the resident was doing, if any thoughts of self harm were voiced, or if any self harm behaviors were exhibited and this should be documented at least every shift. However, interviews with LPN #2 on 07/07/11 at 3:30 PM and RN #1 on 07/08/11 at 2:10 PM revealed these procedures had not been followed.</p> <p>An interview with the Staff Development Coordinator, on 07/13/11 at 09:30 AM, revealed she had not provided training to facility staff regarding suicide precautions. All new hires were provided the policy and procedures for review; however, she did not do any training directly related to suicide precautions.</p> <p>An interview with the facility Administrator, on 07/13/11 at 4:40 PM, revealed she expected staff to "secure" any resident who displayed suicidal behaviors or voiced suicidal thoughts until the physician could be contacted. At that time, the licensed staff would act as directed by the physician and if necessary continue the one-to-one or implement safety checks.</p>	F 490		

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F 490	<p>Continued From page 27</p> <p>The facility implemented the following actions to correct the deficiency:</p> <ul style="list-style-type: none"> -On 06/04/11, the facility initiated suicide precautions. Resident #2's call light was removed, as well as the resident's roommate's call light, on 06/04/11, and both residents were provided a call bell. -On 06/04/11 Resident #2's care plan was updated to include suicide precautions. -Obtained an order, on 06/05/11, for a urinalysis with culture and sensitivity due to increased confusion, agitation and change in behavior. -Obtained an order, on 06/06/11, to begin Ativan 0.5 milligrams (mg) three times a day. -Conducted a care plan meeting with Resident #2's family, on 06/06/11, to discuss resident's situation. Allowed family to bring in sewing machine, to assist resident with adjustment issues, at the family's request. Changed Resident #2's room, at the family's request. -Inserviced all licensed staff, on 06/06/11, on suicidal precautions, to include assigning staff to remain with resident on a one to one basis and notifying the resident's attending physician concerning the resident's behavior. -Provided psychiatric services for Resident #2, on 06/09/11, and implemented psychiatrist's recommendations of trial of the antidepressant Citalopram and to engage the resident's socialization activities. 	F 490		

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F 490	<p>Continued From page 28</p> <p>-Obtained an order, dated 06/09/11 at 10:50 AM, to begin Citalopram 20 mg. every day.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>An observation of Resident #2's room, on 07/05/11 at 12:45 PM, revealed a call bell in place and the call light removed from the room.</p> <p>Observations of Resident #2, on 07/05/11 at 3:30 PM, 07/06/11 at 8:20 AM, 07/06/11 at 9:00 AM and 07/06/11 at 11:00 AM, revealed Resident #2 up in either the dining room or lobby area. Resident's affect was bright and made good eye contact when approached. Resident engaged in activities on 07/05/11 at 3:00 PM and 07/06/11 at 11:00 AM.</p> <p>A record review of Resident #2's current physicians orders revealed the resident remained on Citalopram 20 mg. every day and Ativan 0.5 mg three times a day.</p> <p>Interviews with the DON, on 07/08/11 at 12:00 PM and 07/13/11 at 4:35 PM, revealed she had inserviced licensed staff on 06/06/11 regarding the care of a resident threatening to harm him/herself. The DON stated the purpose of the inservice was to review with the licensed staff what to do when a resident was exhibiting self harm behaviors or threats to someone else.</p> <p>A review of the facility's inservice training report, dated 06/06/11, revealed licensed nurses were inserviced regarding what to do when a resident threatens to harm themselves. Training record</p>	F 490		

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F 490	<p>Continued From page 29</p> <p>indicated staff was to maintain one to one supervision until safety is maintained and to notify the physician for instructions. A review of the signature portion of the training record revealed all licensed staff had signed as having received the training.</p> <p>An interview with the social services director, on 07/08/11 at 11:15 AM, revealed she had met with Resident #2's family on 06/06/11 to discuss resident's behavior. Family requested a room change and to be allowed to bring in a sewing machine to help resident with adjustment issues. She stated room was changed on 06/06/11 and family brought sewing machine to the facility. Family did not want resident sent out of facility for a psychiatric evaluation as did not feel resident was suicidal but was having difficulty adjusting to being at the facility.</p> <p>An interview with Resident #2's daughter, on 07/08/11 at 11:25 AM, revealed the facility had contacted her regarding the resident's behavior. She stated did not feel resident's behavior was suicidal, but rather was related to adjustment issues. Daughter revealed she had told facility she did not want resident sent out of the facility for a psychiatric evaluation. The facility also adjusted the resident's medications and allowed the daughter to bring in a sewing machine, which she had brought to the facility on 06/06/11.</p> <p>Interviews with certified medication technicians (CMT) #1 and #2, on 07/08/11 at 9:30 AM and 10:20 AM, revealed both CMTs were aware of the facility policy on suicidal precautions and how to respond when a resident displayed suicidal behavior or expressed suicidal thoughts. These</p>	F 490		

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F 490	<p>Continued From page 30</p> <p>interventions included to monitor the resident to ensure safety, report the behavior to the licensed staff immediately, remove all harmful items from the resident's room including the call light and to initiate safety checks as directed by the licensed staff.</p> <p>Interviews with certified nurse aids (CNA) #1, #2, #3, #4 and #5, on 07/08/11 at 10:30 AM, 9:45 AM, 9:55 AM, 10:05 AM and 10:10 AM, respectively, revealed all the CNAs aware of the facility policy on suicidal precautions and how to respond when a resident displayed suicidal behavior or expressed suicidal thoughts. These interventions included to monitor the resident to ensure safety, report the behavior to the licensed staff immediately, remove all harmful items from the resident's room including the call light and to initiate safety checks as directed by the licensed staff.</p> <p>Interviews with RN #1 and LPN #4, on 07/08/11 at 2:10 PM and 9:45 AM, respectively, revealed both licensed staff had been provided an inservice on suicide precautions, on 06/06/11, by the DON. Both related knowledge of the inservice to include placing the resident on one to one supervision to ensure safety, contacting the physician to report the resident's behavior, encourage transfer out of the facility for a psychiatric evaluation and initiate safety checks as directed by the physician.</p>	F 490		

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1961, 1971, 1986 Survey under: 2000 existing Facility type: SNF/NF Type of structure: One (1) story Type V111 with partial basement. Smoke Compartment: Five (5) smoke compartments Fire Alarm: Manual initiating devices located at exits. Smoke detectors located at smoke barriers doors near rooms 24/25 and 28/29, dining room and medication room. Sprinkler System: Complete automatic (dry) sprinkler system. Generator: Type II A standard Life Safety Code survey was conducted on 07/07/2011. Glenview Health Care Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was fifty seven (57). The facility is licensed for sixty (60). The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	K 000 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.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K 062 On 7/29/2011, the portable heater was removed from room. We will be utilizing permanent heat source already in room. Replaced the large compressor with smaller compressor.	07-30-11

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

Yvonne W. Cook

TITLE

Administrator

(X6) DATE

08-04-2011

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 062	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure heat supplied to the valve room, was from a permanent heat source, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, sixty (60) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 07/07/2011 at 12:36 PM, revealed a portable heater was located in the valve room. The permanent wall mounted heater was blocked by a large air compressor used to supply air to the dry sprinkler system. The observation was confirmed by the Maintenance Director at time of discovery.</p> <p>Interview on 07/07/2011 at 12:36 PM, with the Maintenance Director, revealed the facility had to replace the old air compressor approximately two (2) to three (3) years ago, and have been using the small space heater since then, due to the new compressor being larger and blocking the wall mounted heater. Further interview, revealed the facility could not produce any documentation stating the heater element of the space heater did not exceed 212 °F.</p> <p>Reference: NFPA 13 (1999 edition) 4-2.5.2 Valve rooms shall be lighted and heated. The source of heat shall be of a permanently installed type. Heat tape shall not be used in lieu of heated valve enclosures to protect the</p>	K 062		

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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 07/07/2011
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 062	Continued From page 2 dry pipe valve and supply pipe against freezing. 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 062			