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

PRINTED: 07/14/2011
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
JUL 2011
OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING B. WING	C 06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	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 AMENDED Abbreviated surveys (KY #15808, KY #15809, KY #15811 and KY#16508) were conducted on 06/06-15/11 to determine the facility's compliance with Federal Regulatory Requirements. KY #15808 and KY#15811 were unsubstantiated with no deficiencies. KY#15809 and KY#16508 were substantiated with deficiencies cited, with the highest S/S being a "D."	F 000	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157	F – 157 1. MD notification was made on 12-9-10 at 6:50 am. 2. DON on 7/5/11reviewed minutes from awareness meeting, and reviewed all reports of incidents and investigations of falls and injuries of unknown origin over the past 6 months to determine if all notifications were made in a timely manner. 3. DON conducted an in-service on 7/5/11reviewing the Notification of change policy with all nurses and educated as to what a significant change is. The Notification Of Change policy will be included in the orientation of all nurses beginning 7-5-11. 4. The nurse manager will review 24 hr. report sheets, and all reports of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Clark	Administrator	7-20-2011

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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F 157	Continued From page 1 regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to consult with the resident's physician in a timely manner for one resident (#4), in the selected sample of 11, related to a significant change in the resident's physical, mental, or psychosocial status. The facility identified a change in Resident #4's physical status on 12/08/10 after a skin assessment completed by Licensed Practical Nurse (LPN) #1. The nurse suspected a fracture of the resident's left leg; however, the physician was not notified of the change until six hours later. Findings include: A review of the facility's policy/procedure, "Notification of Changes," dated 07/01/08, revealed, "This facility will immediately inform the resident; consult with the resident's physician; and if known, notify the designated family member or resident's legal representative when there is a significant change in the resident's physical, mental, or psychosocial status. The following are, but not limited to, those conditions that should be communicated to the physician: Any changes in the medical condition (i.e. weight loss, skin problems, refusal of fluids or	F 157	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* incidents and investigations of falls and injuries of unknown origin weekly to ensure notification was completed timely. The reviews will be presented to the facility QA committee no less than quarterly for 6 months for review and to ensure compliance. 5. Completion date: 7/8/11	

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NAME OF PROVIDER OR SUPPLIER GLASGOW HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	

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F 157	Continued From page 2 medications, medication errors, seizures, SOB, chest pain, reaction to new medication)." A record review revealed Resident #4 was admitted to the facility on 09/06/07, with diagnoses to include Altered Mental Status, Hypertension, Cerebral Vascular Accident, Deficiency Anemia and Alzheimer's Dementia. A review of Resident #4's significant change Minimum Data Set (MDS), dated 10/21/10, revealed the facility assessed the resident's cognitive skills to be severely impaired and required extensive assistance with bed mobility and Activities of Daily Living (ADLs). A review of nurses' notes, dated 12/08/10 at 11:30 PM, revealed a skin assessment was completed by LPN #1, which identified edema with old yellow discoloration to the left thigh and knee, and the second and third digit on the left foot was dark purple. Further review of a nurse's note, dated 12/09/10 at 5:45 AM, revealed LPN #1 contacted the Director of Nursing (DON) to make her aware of the findings. A nurse's note, dated 12/09/10 at 5:59 AM, revealed the facility attempted to contact the resident's primary physician. On 12/09/10 at 6:50 AM, the physician contacted the facility and ordered an X-ray of the resident's left leg and foot. Per the nurse's notes, the X-ray was completed at 12/09/10 at 10:30 AM. Results were received, at 12/09/10 at 11:45 AM, with findings of a distal femur fracture with mild knee degenerative joint disease and osteoporosis present. The resident was transported to the Emergency Room, on 12/09/10 at 2:25 PM, for an	F 157		

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F 157	Continued From page 3 evaluation per an order from the resident's consulting orthopedic physician. An interview with LPN #1, on 06/08/11 at 8:12 AM, revealed she completed a skin assessment on 12/08/10 and noted edema with old yellow discoloration to the left thigh and knee, and the second and third digit on the left foot was dark purple. She stated she suspected an accident may have occurred and a possible fracture was involved, but wanted to monitor the leg throughout the night for any changes. She stated it did not look right and she wanted a second opinion, so she contacted the current DON the next morning, on 12/09/10 at 5:45 AM. She stated she did not contact the physician at that time because the resident exhibited no signs of distress or an acute condition. An interview with the DON, on 06/15/11 at 11:24 AM, revealed she expected staff to contact the physician immediately if new swelling and bruising was discovered. An interview with Resident #4's physician, on 06/08/11 at 9:05 AM, revealed he expected staff to contact him immediately with a significant change in condition.	F 157	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226	F – 226 1. We cannot correct the non-compliance in this situation. An investigation was completed 12-13-10 and the reason for the injury was determined not to be related to abuse nor neglect. 2. The DON reviewed all reports of injuries of unknown origin for past 6 months on 7-5-11 to determine if abuse investigations were initiated and completed per our policy if indicated. 3. An in-service for all nursing staff was conducted on 6/8/11 by DON regarding investigating and reporting injuries of unknown origin. An In-service was conducted on 6/14/11 by the DON to re-educate nurses regarding monitoring and documentation of acute conditions. An in-service on the facility Abuse Policy	

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F 226	Continued From page 4 by: Based on record review and interviews, it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property for one resident (#4), in the selected sample of 11, related to failure to follow the facility's policy regarding abuse. The facility failed to immediately initiate an investigation or contact the acting Director of Nursing (DON) after a discovery of an injury of unknown origin on 12/08/10. Findings include: A review of the facility's policy, "Abuse Prohibition," dated 02/05/03, revealed, "The facility has a zero tolerance for any acts of abuse. This policy creates an avenue for individuals to report acts, incidents, or events related to resident mistreatment, neglect, abuse, and misappropriation of resident property. The Director of Nursing and Administrator, and when appropriate the Governing Body, are to be notified immediately by the charge person who initially receives the report. Events that should be reported and will be investigated include the following: Suspicious bruising of residents, occurrences, patterns, or trends that may constitute abuse. The physician is to be contacted if any injury is determined or if a possible injury should be ruled out. The physician is to be contacted as necessary for other direction as indicated." A record review revealed Resident #4 was admitted to the facility on 09/06/07, with diagnoses to include Altered Mental Status,	F 226	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* was conducted by the DON on 6/28/11. 4. DON will review all reports of injuries of unknown origin to ensure all investigations were initiated immediately and notification was made to DON and the abuse policy was followed if indicated. The reviews will be presented to the facility QA committee no less than quarterly for one year to ensure compliance. 5. Completion date: 7/8/2011	

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F 226	Continued From page 5 Hypertension, Cerebral Vascular Accident, Deficiency Anemia and Alzheimer's Dementia. A review of Resident #4's significant change Minimum Data Set (MDS), dated 10/21/10, revealed the facility assessed the resident's cognitive skills to be severely impaired and required extensive assistance with bed mobility and Activities of Daily Living (ADLs). A review of the facility's investigation, dated 12/09/10, revealed on 12/08/10, State Registered Nurse Aide (SRNA) #2 and SRNA #3 transferred Resident #4 from the wheelchair to the bed after supper. SRNA #2 and SRNA #3 observed swelling to the left leg and the second toe of the resident's foot was "black." Licensed Practical Nurse (LPN) #3 was notified of these findings immediately following Resident #4's care. An interview with LPN #3, on 06/08/11 at 1:44 PM, revealed she was notified by two SRNAs, on 12/08/10, regarding Resident #4's left foot; however, she stated she was not able to assess him/her and reported it to the oncoming shift nurse. An interview with LPN #1, on 06/08/11 at 8:12 AM, revealed she did not recall being notified by the previous shift nurse of the change in Resident #4's skin and stated she discovered the change during a routine skin assessment completed during her shift on 12/08/10 at 11:30 PM. Further interview with LPN #1, on 06/09/11 at 2:45 PM, revealed the skin assessment she completed on 12/08/10 at 11:30 PM revealed edema with old yellow discoloration to the left thigh and knee, and the second and third digit on the left foot was dark	F 226		

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F 226	Continued From page 6 purple. She stated she suspected an accident may have occurred, but did not suspect abuse. She stated it did not look right and wanted a second opinion. She contacted the DON the next morning, on 12/09/10 at 5:45 AM. She stated she did not contact the DON immediately and monitored the resident's condition throughout the night. An interview with the former DON, on 06/08/11 at 3:30 PM, revealed if the nurse was unable to make a determination as to the cause of injury after the initiation of an investigation and staff interviews, she expected to be contacted within a reasonable time frame. An interview with the current DON, on 06/15/11 at 11:24 AM, revealed she expected SRNAs to report discoveries of injuries of unknown origin to the charge nurse. The charge nurse was to initiate an investigation immediately if an injury of unknown origin was identified. If an origin could not be identified within two to three hours, she expected staff to contact her at that time.	F 226	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and interviews, it was determined the facility failed to ensure care plan interventions were followed for	F 282	F – 282 1. Resident #4 is no longer a resident of this facility. The careplan and nurse aide care plan for resident #8 were reviewed to ensure they reflected the services necessary to care for this resident. The careplan and nurse aide care plan were revised as indicated. All necessary devices were identified and found in resident room and determined to be functional. This was completed on 6/6/11by DON. 2. All Care Plans and NACP were audited 6/6/11 by DON, Nurse manager and Restorative nurse to ensure all care needs were addressed and all necessary devices were in place. 3. All staff were in-serviced on 6/28/11by DON regarding following	

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F 282	Continued From page 7 two residents (#4 and #8), in the selected sample of 11. Resident #4 was transferred from the wheelchair to the bed by one staff member instead of two staff members. Assistive devices were not utilized for Resident #8 in accordance with the care plan. Findings include: 1. A record review revealed Resident #4 was admitted to the facility on 09/06/07, with diagnoses to include Altered Mental Status, Hypertension, Cerebral Vascular Accident, Deficiency Anemia and Alzheimer's Dementia. A review of Resident #4's significant change Minimum Data Set (MDS), dated 10/21/10, revealed the facility assessed Resident's cognitive skills to be severely impaired and the resident required extensive assistance of two staff members with bed mobility, transfers, and Activities of Daily Living (ADLs). A review of the Nurse Aide Care Plan, dated 12/10, revealed Resident #4 required total assistance of two staff members for mobility and positioning, and was non-weight bearing. A review of the facility's Final Investigation Report, dated 12/09/10, revealed Resident #4 sustained an injury of an unknown origin, which was a fracture of the left femur. The injury was discovered on 12/08/10 at 11:30 PM, by Licensed Practical Nurse (LPN) #1, following a scheduled skin assessment. An investigation was not initiated until the next morning, on 12/09/10, to determine the cause of the injury. A scenario was identified during the investigation that	F 282	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* the care plan, all staff were instructed on where to find the care plan and the policy regarding signing the care plan. Worksheets are to updated daily and will be provided to the staff at the beginning of their shift. 4. Unit nurses will audit at least 2 nurse aides per day beginning 7-8-11 for 2 weeks, then a minimum of one per day for 2 weeks, ensuring that all nurse aides are audited no less than four times in regards to following the plan of care. They will use the worksheets to audit and will turn the audits into the ADON daily. Any deficient practice will be noted and corrected immediately, the ADON will review the audits to determine if additional education or action is needed. The audit reviews will be presented to the	

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F 282	Continued From page 8 occurred on 12/06/10, in which a State Registered Nurse Aide #1 (SRNA) transferred Resident #4 alone. He/she required assistance of two staff members for transfers. Resident #4 sustained an assisted fall because SRNA #1 was unable to complete the transfer on 12/06/10. SRNA #1 did not notify the charge nurse on duty of this incident. An interview with SRNA #1, on 06/09/11 at 1:19 PM, revealed Resident #4 required assistance of two staff members for bed mobility and transfers. On 12/06/10, Resident #4 sustained a fall when SRNA #1 attempted to transfer the resident alone. However, she stated she should have asked another staff member for assistance to transfer Resident #4 and should have notified the charge nurse immediately after the incident. 2. A record review revealed Resident #8 was admitted to the facility with diagnoses to include Quadriplegia with a Crushed Neck Injury, Anoxic Brain Injury and Depression. A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/02/11, revealed the facility assessed the resident's cognitive skills to be moderately impaired and required extensive assistance of two staff with bed mobility, transfer, bathing and personal hygiene. The resident was non-ambulatory, unable to speak and received nutrition by a Gastrotomy tube (G-tube). A review of the comprehensive care plan, dated 02/16/11 and revised 05/25/11, revealed Resident #8 had a body alarm, check placement every shift, bed bolsters to the bed (2 sets, head and foot) and mats on both sides of the bed.	F 282	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* facility QA committee for review no less than quarterly for one year. 5. Completion date: 7/9/2011	

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F 282	Continued From page 9	F 282		

A review of the Nurse Aide Care Plan, dated 05/11, revealed the resident had bilateral bolster pads while in bed and a personal body alarm, to be checked every shift.

A review of the State Registered Nurse Aide (SRNA) worksheet (a sheet with pertinent information for each resident to ensure appropriate care was provided) revealed the resident had a personal body alarm and bilateral bolster pads while in bed . The work sheet was to be updated daily.

A review of the Falls Risk Screen, dated 05/02/11, revealed the resident was at risk for falls related to the following factors: the inability to stand/walk, he/she required assistance with transfers, was a quadriplegic, incontinent, exhibited poor positioning (leaning, sliding, slumping), had an air mattress on the bed and did not follow directions.

A review of the nurses' notes, dated 05/25/11 at 5:00 PM, revealed Licensed Practical Nurse (LPN) # 3, was called to Resident #8's room by SRNA #4. The resident's head and shoulders were on the floor, legs were on the edge of bed with the bolster holding the resident's legs. The personal body alarm was not attached.

A review of the Post Fall Investigation Tool, dated 05/25/11 at 5:50 PM, revealed the causative factor of the fall was determined to be the loose top strap on the bed bolster. The personal body alarm was not in place.

An observation, on 06/06/11 at 1:30 PM, revealed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/15/2011
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 282	Continued From page 10 Resident #8 was lying in bed with a gel wedge on the right side under the shoulder. The resident was non-verbal and did not shake his/her head yes/no or acknowledge any questions by blinking his/her eyes. The resident displayed constant movement of the head and hands. The settings were on "Five and Fowlers" (Five denotes the firmness of the air mattress and Fowlers denoted the head of the bed (HOB) was elevated for a resident with a G-tube. This corresponded to the setting labeled specifically to the resident posted on the control box at the end of the bed and on the resident's care plan. Two sets of bilateral bed bolsters were intact and tight. A personal body alarm was attached to the resident. The resident had contractures of all four extremities with pillows positioned between his/her knees. Jevity 1.2 was infusing at 55 milliliters (ml) per hour per a G-tube. The HOB was up 30 degrees and the resident was lying on an air mattress. Floor mats were on either side of the bed on the floor. An interview with LPN #3, on 06/06/11 at 3:55 PM, revealed she worked on 05/25/11 when she was summoned to Resident #8's room at approximately 5:00 PM by SRNA # 4. Upon entering the room, the resident's head and shoulders were on the floor on the right side of the resident's bed. The resident's legs were held by the bed bolster which had partially come off the bed with the resident. The bed bolster had two straps, one on each end, and the top strap was loose. The personal body alarm was not attached to the resident. There was no floor mat on the right side of the bed. The LPN stated it was the SRNAs responsibility to ensure all assistive devices and alarms were in place and were to be checked when care was provided. All	F 282		

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GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

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F 282	Continued From page 11 SRNAs were to make a copy of the work sheet after getting their assignments for the shift. She did not monitor to ensure each SRNA had their work sheets. She expected the SRNA to be responsible for making copies and providing the care according to the resident's care outlined on the work sheet. She stated SRNAs were expected to make rounds with the off-going shift and get a report of any new information regarding residents. An interview with SRNA #4, on 06/07/11 at 1:05 PM, revealed she was unfamiliar with Resident #8 and had not checked the resident's care plan nor had made a copy of the work sheet prior to providing care. SRNA #4 was unaware the resident had a personal alarm or floor mats on either side of the bed and did not refer to the resident's care plan to verify the individual care for Resident #8. SRNA #4 stated she usually did, but did not on that day and had no explanation as to why she had not. Additionally, SRNA #4 did not get a report from the off-going shift nor a report from the licensed staff. Interviews with SRNA #6, on 06/07/11 at 10:25 AM, with SRNA #7, on 06/07/11 at 10:25 AM, with SRNA #5, on 06/07/11 at 3:15 PM, with SRNA #2, on 06/07/11 at 3:40 PM, with SRNA #8, on 06/07/11 at 3:50 PM, and with SRNA #9, on 06/09/11 at 2:10 PM, revealed all the SRNAs were to report to the nursing station to look at their assignments for the shift, make copies of the residents' worksheets and provide the care according to the worksheets. The SRNAs were to receive report from the licensed staff and also make rounds with the off-going shift to ensure all assistive devices were in place and functional.	F 282		

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F 282	Continued From page 12 An interview with the Director of Nursing (DON), on 06/09/11 at 10:55 AM, revealed the assignment sheets were always located at the nursing desk. When SRNAs come in on their shift, they were to pick up the assignment sheets and make copies of the worksheet. The worksheets were updated as needed on a daily basis and each aide had to make a new copy each shift to provide the appropriate care during the shift. All SRNAs were oriented to obtaining the worksheet prior to providing care. The DON stated it was all staff's responsibility to check assistive devices when providing care or interacting with a resident. The SRNAs should be checking assistive devices every time care is provided. She stated she expected the staff to follow the resident's plan of care.	F 282	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, for	F 309	F – 309 1. Resident #4 is no longer a resident at this facility. 2. On 7-6-11 the wound care nurse reviewed all New Skin reports for last 3 months to ensure no skin issues had not been addressed, on 7/5/11the DON reviewed 24 hour reports over last month to ensure that no acute conditions were not followed up on. 3. An in-service was done 6/14/11 by DON, Nurse manager, MDS Coordinator, and restorative nurse for all nurses on monitoring of acute conditions, including but not limited to skin conditions. An in-service was conducted on 6/28/11 by DON concerning daily documentation by SRNAs of any new skin conditions. Nurses are to run the report of new skin issues at the end of each shift and turn in to wound care	

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F 309	Continued From page 13 one resident (#4), in the selected sample of 11. On 12/08/10, Licensed Practical Nurse (LPN) #3 failed to assess the resident after she was notified by evening shift nurse aides of a change in Resident #4's skin. Subsequently, the change was not identified until a skin assessment was completed by LPN #1, on 12/08/10 at 11:30 PM. Findings include: A review of the facility's policy/procedure, "Notification of Changes," dated 07/01/08, revealed, "This facility will immediately inform the resident; consult with the resident's physician; and if known, notify the designated family member or resident's legal representative when there is a significant change in the resident's physical, mental, or psychosocial status. The following are, but not limited to, those conditions that should be communicated to the physician: Any changes in the medical condition (i.e. weight loss, skin problems, refusal of fluids or medications, medication errors, seizures, SOB, chest pain, reaction to new medication)." A record review revealed Resident #4 was admitted to the facility on 09/06/07, with diagnoses to include Altered Mental Status, Hypertension, Cerebral Vascular Accident, Deficiency Anemia and Alzheimer's Dementia. A review of Resident #4's significant change Minimum Data Set (MDS), dated 10/21/10, revealed the facility assessed Resident's cognitive skills to be severely impaired and the resident required extensive assistance with bed mobility and Activities of Daily Living (ADLs).	F 309	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* nurse with assessment and findings. Staff nurses were in-serviced on 6/28/11 by DON regarding the use of 24 hour report to note any acute conditions and appropriate follow up to same. 4. The Nurse Manager will review 24 Hour reports weekly to ensure that acute conditions were followed up on appropriately. The wound care nurse will audit the new skin issues report weekly to ensure appropriate notification has occurred. The findings from these audits will be reported to the facility QA committee for review no less than quarterly for 6 months. 5. Completion date: 7/8/2011	

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F 309	Continued From page 14 A review of the facility's investigation, dated 12/09/10, revealed on 12/08/10, State Registered Nurse Aide (SRNA) #2 and SRNA #3 transferred Resident #4 from the wheelchair to the bed after supper. SRNA #2 and SRNA #3 observed swelling to the left leg and the second toe of the resident's foot was "black." LPN #3 was notified of these findings immediately following care to Resident #4. An interview with LPN #3, on 06/08/11 at 1:44 PM, revealed she was notified by two SRNAs, on 12/08/10, regarding Resident #4's left foot; however, she stated she was not able to assess him/her and she reported it to the oncoming shift nurse. An interview with LPN #1, on 06/08/11 at 8:12 AM, revealed she did not recall being notified by the previous shift nurse of the change in Resident #4's skin and discovered the change during a routine skin assessment completed during her shift on 12/08/10 at 11:30 PM. An interview with the Director of Nursing (DON), on 06/15/11 at 11:24 AM, revealed she expected the nurses to assess a resident if an issue was brought to their attention. Nurses were to use sound nursing judgment and based on the resident's condition, notify the resident's physician.	F 309	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* F – 323 1. Resident #4 is no longer a resident of this facility. The careplan and nurse aide care plan for resident #8 were reviewed to ensure they reflected the services necessary to care for this resident. The careplan and nurse aide care plan were revised as indicated. All necessary devices were identified and found in resident room and determined to be functional. This was completed on 6/6/11by DON. 2. All Care Plans and NACP were audited 6/6/11 by DON, Nurse manager and Restorative nurse to ensure all care needs were addressed and all necessary devices were in place. 3. Facility in-service was conducted for SRNAs on 6/13/11 regarding the	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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	F 323		

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F 323	Continued From page 15 prevent accidents. This REQUIREMENT is/not met as evidenced by: Based on observation, record reviews and interviews, it was determined the facility failed to ensure adequate supervision and assistive devices to prevent accidents for two residents (#4 and #8), in the selected sample of 11. Resident #8 sustained a fall, without injury, when the State Registered Nurse Aide (SRNA) did not ensure the bed bolster was properly applied. The personal clip alarm was not applied to the resident according to the care plan. Additionally, Resident #4 was improperly transferred which resulted in an assisted fall. Findings include: 1. A review of the facility policy, "Falls Management," dated 01/01/2010, revealed, "A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force." A record review revealed Resident #4 was admitted to the facility on 09/06/07, with diagnoses to include Altered Mental Status, Hypertension, Cerebral Vascular Accident, Deficiency Anemia and Alzheimer's Dementia. A review of Resident #4's significant change Minimum Data Set (MDS), dated 10/21/10, revealed the facility assessed his/her cognitive skills to be severely impaired and required	F 323	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* proper positioning of dependent residents by Therapy department. In-service conducted by SCM on 5/31/11 for all nursing associates with regards to low air loss mattress settings. Information on low air loss mattresses were placed on TAR and in the NACP book. An in-service was conducted on proper application of Bolsters by DON and nurse manager on 6/14/11 for all nursing staff. All staff were in-serviced on 6/28/11by DON regarding following the care plan, all staff were instructed on where to find the care plan and the policy regarding signing the care plan. Worksheets are to updated daily and will be provided to	

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F 323	Continued From page 16 extensive assistance of two staff members with bed mobility, transfers, and Activities of Daily Living (ADLs). A review of the Nurse Aide Care Plan, dated 12/10, revealed Resident #4 required total assistance of two staff members for mobility and positioning, and was non-weight bearing. A review of the facility's Final Investigation Report, dated 12/09/10, revealed Resident #4 sustained an injury of an unknown origin, which was a fracture of the left femur. The injury was discovered on 12/08/10 at 11:30 PM, by Licensed Practical Nurse (LPN) #1, following a scheduled skin assessment. An investigation was not initiated until 12/09/10 to determine the cause of the injury. A scenario was identified during the investigation that occurred on 12/06/10, in which SRNA #1 transferred Resident #4 alone. He/she required assistance of two staff members for transfers. Resident #4 sustained an assisted fall because SRNA #1 was unable to complete the transfer alone on 12/06/10. SRNA #1 did not notify the charge nurse on duty of this incident. An interview with SRNA #1, on 06/09/11 at 1:19 PM, revealed Resident #4 required assistance of two staff members for bed mobility and transfers. On 12/06/10, Resident #4 sustained a fall when SRNA #1 attempted to transfer the resident alone. However, she stated she should have asked another staff member for assistance to transfer Resident #4 and should have notified the charge nurse immediately after the incident. 2. A record review revealed Resident #8 was admitted to the facility with diagnoses to include	F 323	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* the staff at the beginning of their shift. 4. Unit nurses will audit at least 2 nurse aides per day beginning 7-8-11 for 2 weeks, then a minimum of one per day for 2 weeks, ensuring that all nurse aides are audited no less than four times in regards to following the plan of care. They will use the worksheets to audit and will turn the audits into the ADON daily. Any deficient practice will be noted and corrected immediately, the ADON will review the audits to determine if additional education or action is needed. The audit reviews will be presented to the facility QA committee for review no less than quarterly for one year. 5. Completion date: 7/9/2011	

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F 323	Continued From page 17 Quadriplegia with a Crushed Neck Injury, Anoxic Brain Injury and Depression. A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/02/11, revealed the facility assessed the resident's cognitive skills to be moderately impaired and required extensive assistance of two staff with bed mobility, transfer, bathing and personal hygiene. The resident was non-ambulatory, unable to speak and received nutrition by a Gastrotomy tube (G-tube). A review of the comprehensive care plan, dated 02/16/11 and revised 05/25/11, revealed Resident #8 had a body alarm, check placement every shift, bed bolsters to bed (2 sets, head and foot) and mats on both sides of bed. A review of the Certified Nurse Aide Care Plan, dated 05/11, revealed the resident had bilateral bolster pads while in bed and a personal body alarm to be checked every shift. A review of the State Registered Nurse Aide (SRNA) worksheet (updated daily), Section 2, revealed Resident #8 had bolsters on the bed and had bed/chair alarms. A review of the Falls Risk Screen, dated 05/02/11, revealed the resident was at risk for falls related to the following factors: the inability to stand/walk, he/she required assistance with transfers, was a quadriplegic, incontinent, exhibited poor positioning (leaning, sliding, slumping), had an air mattress on the bed and did not follow directions. A review of the nurses' notes, dated 05/25/11 at	F 323		

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F 323	Continued From page 18 5:00 PM, revealed Licensed Practical Nurse (LPN) # 3, was called to Resident #8's room by SRNA #4. The resident's head and shoulders were on the floor, legs were on the edge of the bed bolster which were holding the resident's legs. The personal body alarm was not attached. The head of the bed (HOB) was elevated 30 degrees (for G-tube feeding). The resident was assessed by LPN #3 and revealed no injuries. Incontinent care was provided by SRNA #4 and SRNA #5 and the resident was then positioned in the middle of the bed, the bed bolster strap was tightened and the body alarm was in place. A review of the Post Fall Investigation Tool, dated 05/25/11 at 5:50 PM, revealed the causative factor of the fall was the bed bolster's top strap, which was loose. The personal body alarm was not in place. An observation, on 06/06/11 at 1:30 PM, revealed Resident #8 was lying in bed with a wedge on the right side. The resident was non-verbal and did not acknowledge any questions. The resident displayed constant movement of the head and hands. The settings were on "Five and Fowlers". This corresponded to the setting labeled specifically for the resident. The settings were posted on the control box at the end of the bed and on the resident's care plan. Two sets of bilateral bed bolsters were intact and tight and a personal body alarm was attached to the resident. The resident had contractures of all four extremities and pillows were positioned between his/her knees. A G-tube was infusing Jevity 1.2 was infusing at 55 milliliters (ml) per hour per a G-tube. The HOB was up 30 degrees and the resident was on an air mattress. Floor	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
F 323	Continued From page 19 mats were on the floor on both sides of the bed. An interview with SRNA #4, on 06/07/11 at 1:05 PM, revealed she was unfamiliar with Resident #8 and had not checked the resident's care plan nor made a copy of the work sheet (a sheet with pertinent resident information utilized to provide appropriate care for that resident) prior to providing care. SRNA #4 stated she was not provided information sheets and did not know about them. The SRNA was unaware the resident had a personal alarm or floor mats on both sides of the bed. The SRNA did not get a report from the nurse and did not get a report from the off-going SRNAs. SRNA #4 stated she usually did, but had no explanation as to why she had not at that time. She saw Resident #8 at approximately 4:00 PM on 05/25/11 when she checked the resident during a round. SRNA #4 had positioned Resident #8 on the right side with a positioning pillow under the left shoulder. SRNA #4 did not check the bed bolsters to ensure they were secure and did not see a personal body alarm. At approximately 5:30 PM, the SRNA walked down the hall and passed by Resident #8's room to assist SRNA #5. SRNA #4 noticed the resident in the bed. On the return trip in the hall, approximately 10 minutes later, she did not see Resident #8 in the bed. When SRNA #4 entered the room, she saw the resident on the right side of the bed, partially on the floor and partially on the bed with the bolster under the resident's legs. At that point, SRNA #4 called for SRNA #5 to go get the nurse. An interview with SRNA #5, on 06/07/11 at 3:15 PM, revealed she worked on 05/25/11 with SRNA #4. The first thing the SRNA did at the beginning	F 323		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185340		C 06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

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F 323	Continued From page 20 of the shift was to get the assignment and make a copy of the SRNA work sheets. SRNA #5 stated she asked SRNA #4 for some help with another resident at the end of the hall at approximately 5:15-5:30 PM on 05/25/11. As SRNA #5 returned from another resident's room, SRNA #4 called for someone to get the nurse. SRNA #5 summoned the nurse. An interview with LPN #3, on 06/06/11 at 3:55 PM, revealed she worked on 05/25/11 when she was summoned to Resident #8's room at approximately 5:00 PM by SRNA # 4. Upon entering the room, the resident's head and shoulders were on the floor on the right side of the resident's bed. The resident's legs were held by the bed bolster which had partially come off the bed with the resident. The bed bolster had two straps, one on each end, and the top strap was loose. The personal body alarm was not attached to the resident. There was no floor mat on the right side of the bed. The LPN stated she saw Resident #8 at approximately 4:30 PM when she cleared the G-tube pump and Resident #8 was lying on the bed; however, LPN #3 did not check the bolsters or the personal body alarm. She could not recall a floor mat on the right side of the bed; however, there was a mat on the left side of the bed on the floor. An assessment of Resident #8 was completed and no injuries were noted. The resident exhibited no grimacing or moaning and was placed back into the bed. LPN #3 re-educated the SRNAs regarding assistive devices being functional and in place and ensuring residents were placed in the middle of the bed for safety. Interviews conducted with SRNA #6, on 06/07/11	F 323		

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F 323	Continued From page 21 at 10:25 AM, with SRNA #7, on 06/07/11 at 10:25 AM, with SRNA #2, on 06/07/11 at 3:40 PM, with SRNA #8, on 06/07/11 at 3:50 PM, and with SRNA #9, on 06/09/11 at 2:10 PM, revealed all the SRNAs reported to the nursing station to look at their assignments for the shift, made copies of the resident's worksheets and provided the care according to the worksheets. The SRNAs received report from the licensed staff and also made rounds with the off-going shift to ensure all assistive devices were in place and functional. An interview with the Director of Nursing (DON), on 06/09/11 at 10:55 AM, revealed the assignment sheets were always located at the nursing desk. When SRNAs come in on their shift, they pick up the assignment sheets and make copies of the worksheet. The worksheets were updated as needed daily and each aide had to make a new copy for them to have to provide the appropriate care during the shift. The current worksheet had been in effect for approximately six months. All SRNAs were oriented to obtain the worksheet prior to providing care. The DON stated it was all staff's responsibility to check assistive devices when providing care or interacting with a resident. The SRNAs should check assistive devices every time care is provided. She stated she expected the staff to follow the resident's plan of care.	F 323	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514	F – 514 1. Resident #4 is no longer a resident at this facility. 2. On 7-6-11 the wound care nurse reviewed all New Skin reports for last 3 months to ensure no skin issues had not been addressed, on 7/5/11the DON reviewed 24 hour reports over last month to ensure that no acute conditions were not followed up on. 3. An in-service was done 6/14/11 by DON, Nurse manager, MDS Coordinator, and restorative nurse for all nurses on monitoring of acute conditions, including but not limited to skin conditions. An in-service was conducted on 6/28/11 by DON concerning daily documentation by SRNAs of any new skin conditions. Nurses are to	

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NAME OF PROVIDER OR SUPPLIER GLASGOW HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141	

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F 514	Continued From page 22 systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for one resident (#4), in the selected sample of eleven. The facility failed to document clinical assessments of Resident #4 related to a change in the resident's physical status. Findings include: A record review revealed Resident #4 was admitted to the facility on 09/06/07, with diagnoses to include Altered Mental Status, Hypertension, Cerebral Vascular Accident, Deficiency Anemia and Alzheimer's Dementia A review of nurse's notes, dated 06/11/11 at 3:00 PM, revealed Registered Nurse (RN) #1 noted reddened areas on the resident's left hip and a small reddened area on the right hip. The note further revealed RN #1 continued to monitor the areas. Further review of the nurse's notes revealed no	F 514	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* run the report of new skin issues at the end of each shift and turn in to wound care nurse with assessment and findings. Staff nurses were in-serviced on 6/28/11 by DON regarding the use of 24 hour report to note any acute conditions and appropriate follow up to same. 4. The Nurse Manager will review 24 Hour reports weekly to ensure that acute conditions were followed up on appropriately. The wound care nurse will audit the new skin issues report weekly to ensure appropriate notification has occurred. The findings from these audits will be reported to the facility QA committee for review no less than quarterly for 6 months. 5. Completion date: 7/8/2011	

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F 514	Continued From page 23 documentation until 06/12/11 at 9:00 AM, when RN #1 charted Resident #4's left leg was red and hot to touch and the area on the right hip increased in size. The on-call physician was contacted and the resident was subsequently transferred to the local hospital. There was no evidence in the clinical record of any assessments completed on Resident #4 from the time the reddened areas were identified on 06/11/11 at 3:00 PM until 06/12/11 at 9:00 AM when the resident required transfer to the local hospital. An interview with RN #1, on 06/14/11 at 10:55 AM, revealed when she first discovered the reddened areas on Resident #4's left and right hips, it appeared to look like a rash. RN #1 revealed the areas may have been caused by the brief the resident wore. She stated she did not contact the physician at the time the areas were discovered because there really was not anything to tell the physician at that point, so she monitored the areas to see if there was any improvement or decline. RN #1 revealed she assessed the areas again around 5:00 PM and 6:00 PM but failed to chart either assessment. She stated she informed the night nurse of the areas and the need to monitor the areas throughout the night. An interview with Licensed Practical Nurse (LPN) #6, on 06/14/11 at 1:10 PM, revealed RN #1 informed her of the areas on Resident #4's hips during report on 06/11/11. LPN #6 revealed she observed the areas 06/12/11 at 12:00 AM and 06/12/11 at 6:00 AM and the areas looked like a rash. She revealed she did not chart her	F 514		

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F 514	Continued From page 24 assessments of the areas. An interview with the Director of Nursing (DON), on 06/15/11 at 11:20 AM, revealed she expected staff to monitor any newly identified acute condition at least every four hours, but if the issue was an acute skin issue other than a pressure ulcer, she expected staff to monitor every two hours to see if the area resolved or worsened. She revealed she expected the licensed staff to document assessments of the acute condition in the nurse's notes of the clinical record.	F 514		