STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	02/08/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF GLASGOW REHAB & WELLNESS C	220 WESTWOOD ST. GLASGOW, KY 42141

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0241 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintains/enhances resident's dignity and respect in full recognition of his/her individuality, and refrain from practices demeaning to two (2) of six (6) sampled residents (Resident #6 and Resident #7). The facility failed to empty Resident #7's [MEDICAL CONDITION] bag in a timely manner resulting in the [MEDICAL CONDITION] bag bursting open and spilling feces on the resident. Resident #7 stated it was so humiliating and dirty. In addition, the facility failed to toilet Resident #6 in a timely manner to prevent incontinent episodes. Resident #6 stated the incidents made him/her feel dirty, ashamed and humiliated. The findings include: Review of the policy titled, Resident Rights, not dated, revealed employees shall treat all residents with kindness, respect, and dignity. Residents are entitled to exercise their rights and privileges to the fullest extent possible. The facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. 1. Record review revealed the facility admitted Resident #6 on 10/21/15 with [DIAGNOSES REDACTED]. Further review revealed Resident #6 also has a Left [MEDICAL CONDITION] which was performed in July 2016. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/23/17, revealed the facility assessed Resident #6's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Further review of the MDS assessment revealed the resident was continent of bowel and occasionally incontinent of bladder. Interview with Resident #6, on 02/07/26 at 3:30 PM, revealed he/she had to pee on myself multiple times due to staff not answering call lights on time. The resident stated it mostly happens on night shift between the hours of 2:00 AM and 5:00 AM. The resident revealed it takes forty-five (45) minutes to over an hour for the call light to be answered at night. The resident stated he/she would not be incontinent if call lights were answered in a timely manner and he/she has called the nurses station by cell phone to reach the nurse and tell her he/she needs to go to the restroom. Resident #6 stated it makes him/her feel dirty, ashamed and humiliated when it happens which is at least five (5) times a week. Interviews on 02/08/17 with Certified Nurse Aide (CNA) #1 at 6:05 AM and CNA #2 at 6:15 AM revealed there has only been two (2) CNA's on night shift this past week and it is impossible to care for sixty (60) residents, especially when there are multiple residents that require the assistance of two (2) staff. They stated it was impossible to answer the call light in a timely manner and residents may have to wait over an hour to get help. Interview with Licensed Practical Nurse (LPN) #1, on 02/08/17 at 5:00 AM, revealed Resident #6 often calls her from the room from his/her cell phone to let her know that he/she needs to urinate. She stated the call light above the door on Resident #6's room cannot be seen from the hallway as the hall has a double doorway that obstructs the view of the light and unless staff go through the double doors, the light cannot be seen. She stated there is no audible call system that can be heard by staff so Resident #6 often has incontinent accidents. 2. Record review revealed the facility admitted Resident #7 on 08/15/15 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated 12/9/16 revealed the facility assessed Resident #7's cognition as intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Interview with Resident #7 on 02/07/17 at 2:15 PM revealed it takes a long time for staff to answer call lights especially between the hours of 2:00 AM and 4:00 AM. The resident stated, I can't get anyone to answer the call light. The resident stated it makes him/her feel anxious and the anxiety causes me to have chest pain. He/she further revealed his/her [MEDICAL CONDITION] bag burst open two (2) days ago and stool went all over him/her because staff had not answered his/her call light. The resident stated, I had stool all over me and it was so humiliating and dirty. He/she further stated it has happened before. Interview with Certified Nurse Aide (CNA) #1, on 02/08/17 at 6:05 AM, revealed she worked nights and could not get to Resident #7 before his/her [MEDICAL CONDITION] burst open. CNA #1 stated Resident #7 had his/her call light on and she was unable to get to the resident before it burst. She revealed she cleaned the resident up after the feces had spilled out and over the resident. She stated she can empty the [MEDICAL CONDITION] but could not change the bag. She stated the resident said his/her light had been on for a while and she couldn't get to him/her. Interview with Licensed Practical Nurse (LPN) #1, on 02/08/17 at 5:30 AM, revealed Resident #7 has had the [MEDICAL CONDITION] bag burst open recently but she was not sure of the date. She stated if the [MEDICAL CONDITION] bag is not emptied on time then the stool pushes the bag causing the wafer and bag to separate and potentially spilling feces onto the resident and bed. She revealed it had happened a few times because staff were not able to respond in time to change it and the incidents had happened in the last two (2) weeks. She stated the resident becomes very upset because the stool spills out on him/her. She becomes very anxious and his/her blood pressure increased. She stated licensed staff would stop and help the CNAs but even with helping them they could not answer all the lights timely. Interview with the Administrator and Director of Nursing (DON), on 02/08/17 at 3:30 PM, revealed they expected call lights would be answered in a timely manner and would not want residents to be incontinent if it could be prevented and everyone has the right to be kept as clean and dry as possible. They also revealed they expected all staff to respect residents' rights and ensure dignity as much as possible.
F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy and procedure review, it was determined the facility failed to follow the plan of care for two (2) of six (6) sampled residents (Resident #6 and #7). Resident #6 was care planned to encourage the resident to ask for assistance as soon as he/she has the urge to urinate and/or defecate; however, the staff failed to answer the resident's call light timely so the resident could be toileted to prevent the resident from being incontinent and feeling dirty, humiliated and embarrassed. Resident #7 was care planned to change [MEDICAL CONDITION] bag and wafer as indicated; however, the facility staff failed to change the resident's [MEDICAL CONDITION] bag timely to prevent the [MEDICAL CONDITION] bag from bursting off the stoma and feces to pour on to the resident. This caused the resident to feel dirty and humiliated. The findings include:

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

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

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F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) Review of facility policy titled, Care Plans-Comprehensive, policy statement revealed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The Guideline #1 states the Nurse/Interdisciplinary Team develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The comprehensive care plan will be developed with participation from the resident, resident's family and/or responsible party as indicated. Record review revealed the facility admitted Resident #6 on 10/21/15 with [DIAGNOSES REDACTED]. Resident #6 also has a Left [MEDICAL CONDITION] which was performed in 7/2016. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/23/17, revealed the facility assessed Resident #6's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Review of Resident #6's Comprehensive Care Plan for risk for total loss of bladder and bowel control related to muscle weakness, history of [MEDICAL CONDITIONS] and [MEDICAL CONDITION], dated 04/29/15, revealed an intervention to encourage the resident to ask for assistance as soon as he/she has the urge to urinate and/or defecate. However, interview with Resident #6, on 02/07/16 at 3:30 PM, revealed he/she has had to pee on myself multiple times due to staff not answering the call lights on time. Resident #6 stated it happens mostly on night shift between the hours of 2:00 AM and 5:00 AM because it takes as long as forty-five (45) minutes to over an hour for the call light to be answered. The resident further revealed he/she has called the nurses station by cell phone to reach the nurse and tell her he/she needs to go to the restroom. The resident stated it happens at least five (5) times in a week and makes him/her feel like no one cares and I am dirty and embarrassed. Interviews on 02/08/17 with Certified Nurse Aide (CNA) #1 at 6:05 AM, and CNA #2 at 6:15 AM, revealed Resident #6 uses his/her call light when he/she needs to be toileted. They stated the resident is continent as long as staff can answer the call light timely to toilet the resident. They stated staff cannot answer call lights in a timely manner due to there being only two (2) CNAs and revealed residents may have to wait over an hour to get help. Interview with Licensed Practical Nurse (LPN) #1, on 02/08/17 at 5:00 AM, revealed Resident #6 is normally continent and often calls her from the room from his/her cell phone to let her know that he/she needs to urinate. She stated the call light above the door on Resident #6's room cannot be seen from the hallway as the hall has a double doorway that obstructs the view of the light and unless staff go through the double doors, the light cannot be seen. She stated there is no audible call system that can be heard by staff so Resident #6 often has incontinent accidents. 2. Record review revealed the facility admitted Resident #7 on 08/15/15 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated 12/09/16, revealed the facility assessed Resident #7's cognition as intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Review of the Comprehensive Care Plan for Risk for complications related to [MEDICAL CONDITION] and [MEDICAL CONDITION], dated 08/30/16, revealed a goal to not have complications of ostomies without appropriate nursing interventions through next review date, and an intervention to change the [MEDICAL CONDITION] bag and wafer as indicated. However, interview with Resident #7, on 02/07/17 at 2:15 PM, revealed he/she stated, My [MEDICAL CONDITION] bag burst open two (2) days ago and I had stool all over me and it has happened before. He/she stated it was so humiliating and dirty. The resident stated the bag was not emptied in time before it burst open. The resident stated it happens on night shift and has happened a few times. He/she stated each time he/she had pushed the call light and no one had answered before the [MEDICAL CONDITION] bag burst open. Interview with CNA #1, on 02/08/17 at 6:05 AM, revealed she worked nights and could not get to Resident #7 before his/her [MEDICAL CONDITION] burst open. CNA #1 stated Resident #7 had his/her call light on and she was unable to get to the resident before it burst. She revealed she cleaned the resident up after the feces had spilled out and over the resident. She stated she can empty the [MEDICAL CONDITION] but could not change the bag. She stated the resident said his/her light had been on for a while and she couldn't get to him/her. Interview with LPN #1, on 02/08/17 at 5:30 AM, revealed Resident #7 has had the [MEDICAL CONDITION] bag burst open recently but she was not sure of the date. She revealed it had happened a few times because staff were not able to respond in time to change it and the incidents had happened in the last two (2) weeks. She stated the resident becomes very upset because the stool spills out on him/her and becomes very anxious and his/her blood pressure has increased. She stated licensed staff would stop and help the CNAs but even with helping them they could not answer all the lights. Interview with the Administrator and Director of Nursing (DON), on 02/08/17 at 3:30 PM, revealed they expected all staff to follow care plans as written.
F 0310 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that each residents' abilities in activities of daily living do not decline, unless unavoidable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of Lippincott's Nursing Procedures, fifth edition; it was determined the facility failed to provide appropriate treatment and services to ensure residents' abilities in toileting do not diminish for one (1) of six (6) sampled residents (Resident #6), Resident #6 was assessed as continent of bowel and occasionally incontinent of bladder and required the assistance of staff for toileting: however, staff failed to toilet the resident in a timely manner which caused the resident to have incontinent episodes. Resident #6 stated it made him/her feel dirty, ashamed and humiliated when it happens which is at least five (5) times a week The findings include: Review of the facility's Lippincott's Nursing Procedures Fifth Edition regarding Bedpan and Urinal Management, using a commode, Incontinence Management, and Correcting Urinary Incontinence with bladder retraining revealed incontinence is not a disease nor a part of normal aging. Incontinence may be caused by restricted mobility. Bedpan and urinal should be offered frequently-before meals, visiting hours, during morning and evening care, and at the time of any treatments or procedures. Using a commode is an alternative to a bedpan. The bedpan allows the patient to assume his/her normal elimination posture which aids in defecation. Record review revealed the facility admitted Resident #6 on 10/21/15 with [DIAGNOSES REDACTED]. Further review revealed Resident #6 also has a Left [MEDICAL CONDITION] which was performed in July 2016. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/23/17, revealed the facility assessed Resident #6's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Further review of the MDS assessment, revealed the resident was continent of bowel and occasionally incontinent of bladder. Review of the Comprehensive Care Plan for at risk for skin compromises, dated 04/29/15, revealed an intervention to toilet per schedule and an intervention, dated 01/31/17, to utilize bedside commode at night. Review of Resident #6's Nurse Aide Care Plan, dated 05/30/14, revealed an update, dated 06/03/14, to toilet upon rising and at bedtime, and an update, dated 01/31/17, to use bedside commode at night, no bedpans. Interview with Resident #6, on 02/07/16 at 3:30 PM, revealed he/she had to pee on myself multiple times due to staff not answering call lights on time. The resident stated it mostly happens on night shift between the hours of 2:00 AM and 5:00 AM. The resident revealed it takes forty-five (45) minutes to over an hour for the call light to be answered at night. The resident stated he/she would not be incontinent if call lights were answered in a timely manner and he/she has called the nurses station by cell phone to reach the nurse and tell her he/she needs to go to the restroom. Resident #6 further stated it makes him/her feel dirty, ashamed and humiliated when it happens which is at least five (5) times a week. Interview with Certified Nurse Aide (CNA) #1, on 02/08/17 at 6:05 AM, revealed she works short on nights most nights. CNA #1 stated there was only two (2) CNA's and two (2) licensed staff this past week and it is impossible to care for sixty (60) residents timely especially when there are multiple residents that require two (2) assist. She revealed staff cannot answer call lights in a timely manner and revealed residents may have to wait over an hour to get help. She revealed Resident #6 was continent if the resident received help to the bathroom or a bed pan in time. Interview with CNA #2, on 02/08/17 at 6:15 AM, revealed she was called in today at 3:30 AM to help with residents. CNA #2 stated it is impossible to get around to everyone for turning, changing, toileting and getting out of bed when there is

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F 0310 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) only two (2) CNA's. She stated Resident #6's was normally continent but when it takes too long to answer the call light due to not enough staff the resident is incontinent. Interview with Licensed Practical Nurse (LPN) #1, on 02/08/17 at 5:00 AM, revealed Resident #6 is normally continent and often calls her from the room from his/her cell phone to let her know that she needs to urinate. She stated the call light above the door on Resident #6's room cannot be seen from the hallway as the hall has a double doorway that obstructs the view of the light and unless staff go through the double doors, the light cannot be seen. She stated there is no audible call system that can be heard by staff so Resident #6 often has incontinent accidents. was resident normally continent Interview with Administrator and Director of Nursing, on 02/08/17 at 3:30 PM, revealed they expected call lights would be answered in a timely manner so residents would be as continent as possible.
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy and procedure review, it was determined the facility failed to ensure one (1) of six (6) sampled residents (Resident #6), who entered the facility without pressure sores did not develop pressure sores. Resident #6 was identified as having a Suspected Deep Tissue Injury on the right buttock and a coccyx wound with green exudate and sloughing on 02/01/17 with Physician's Orders received to apply [MEDICATION NAME]/Criticaid cream 1:1 ratio topically to the coccyx and right buttock two (2) times a day. However, the facility failed to treat the wound from 02/05/17-02/07/17 (five treatments) due to the medication not being available. In addition, the facility failed to ensure the resident was toileted timely to prevent possible skin breakdown. The findings include: Review of the facility policy titled, Pressure Ulcer Treatment, not dated, revealed the purpose of the policy is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. The Guideline Steps revealed the pressure ulcer treatment program should focus on the following strategies: assessing the resident and the pressure ulcers, managing tissue loads, pressure ulcer care, managing bacterial colonization and infection, operative repair of the pressure ulcers, and education and quality improvement. Record review revealed the facility admitted Resident #6 on 10/21/15 with [DIAGNOSES REDACTED]. Further record review revealed Resident #6 also has a Left [MEDICAL CONDITION] which was performed in July 2016. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/23/17, revealed the facility assessed Resident #6's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Further review of the MDS assessment revealed the resident was at risk for pressure ulcers with no pressure sores identified at this time. Review of the Comprehensive Care Plan for at Risk for skin compromises, dated 04/29/15, revealed an intervention to toilet per schedule and turn and reposition every two (2) hours and as needed; and review of the Certified Nurse Aide Care Plan, dated 05/30/14, revealed to toilet upon arising and at bed time and to turn and reposition every two (2) hours and as needed. Review of a Weekly Skin assessment, dated 01/29/17, completed by Licensed Practical Nurse #1 revealed a Suspected Deep Tissue Injury (SDTI) was identified to the right buttock with no measurements and it was described as a dark purple area, and an area to coccyx was described as a scar with no measurements. No other wounds were identified. Review of Initial Weekly Wound Assessment, dated 02/01/17, revealed a SDTI measuring five (5) by three (3) centimeters (cm) with no depth to right buttock and no description. A periwound to the sacrum was identified and described as having slough, green exudate and a mild odor; however, there were no measurements. Review of a Physician Order, dated 02/01/17, revealed to apply [MEDICATION NAME]/Criticaid cream 1:1 ratio topically to the coccyx and right buttock two (2) times a day. Review of the Comprehensive Care Plan for Impaired Skin Integrity, dated 01/30/17, revealed an intervention dated 01/31/17 to use bedside commode due to friction from bedpan at night and to apply Silvadine/Criticaid cream to coccyx and right buttock two (2) times a day (BID) to wound. Review of the February 2017 Medication Administration Record [REDACTED]. Observation of Resident #6's Wound Assessment conducted by Advanced Practice Registered Nurse (APRN) #1, on 02/08/17 at 10:00 AM, revealed she determined the wounds were caused from pressure resulting from a deep tissue injury. She stated incontinence of urine and feces would inhibit healing of the wounds and potentially cause the wounds to become worse. When the APRN told the resident that she would be cleaning the wound first before assessing, the resident stated no one cleaned his/her wound at any time. The assessment revealed the pressure sores had worsened as the sacral measurements were 0.8 cm x 0.8 cm x 0.1 cm unstageable and described as slough. green in color and the right buttock wound measurements were 3.2 cm x 3.0 cm x 0.2 cm, described as unstageable with eschar. Interview with Resident #6, on 02/07/17 at 3:30 PM, revealed he/she has incontinent episodes on nights due to staff not answering the call light timely and it happens at least five times a week. The resident stated it takes forty-five (45) minutes to over an hour for the call light to be answered at night. The resident revealed he/she would not be incontinent if call lights were answered in a timely manner and he/she has called the nurses station by cell phone to reach the nurse and tell her he/she needs to go to the restroom. Resident #6 also revealed no medication had been applied to his/her wounds for two (2) days because it was not available. Resident #6 stated the nurse had told her it was ordered and would be here the next day. Interview with Licensed Practical Nurse #1, on 02/08/17 at 5:00 AM, revealed Resident #6's medication had been replaced and she had applied it the night of 02/07/17 but the resident had been out of the medication for two (2) and a half days. She was unable to provide an explanation as to why the medication had run out. Interview with Director of Nursing and Administrator, on 02/08/17 at 3:30 PM, revealed they expected staff to provide toileting timely to prevent skin breakdown and to ensure medication was available to ensure treatments were provided as ordered.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy and procedure review, it was determined the facility failed to ensure one (1) of six (6) sampled residents (Resident #7) received adequate supervision and assistance devices to prevent accidents. On 01/27/17, the Physical Therapy Assistant (PTA) was ambulating Resident #7 without using a gait belt per facility policy when the resident tripped and fell to the floor sustaining a fracture to his/her left 5th finger. The findings include: Review of facility policy titled, Fall Policy, last reviewed 06/01/15, revealed it is the intent of this facility to provide residents with assistance and supervision in an effort to minimize the risk of falls and fall related injuries. Review of the facility Gait Belt Policy, last revised March 2011, revealed each employee who provides direct resident care shall sign an agreement regarding our Gait Belt protocol. Each employee who provides direct resident care shall use a gait belt during ambulation, transfer or movement of residents. In addition, under Educational Guidelines, gait belts Procedural Step #12 revealed how to control a fall: If resident begins to fall, use the gait belt to draw the resident close to your body with the belt and gently and slowly lower the resident to the floor by allowing him/her to slide down your leg. Record review revealed the facility admitted Resident #7 on 08/15/15 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 12/09/16, revealed the facility assessed Resident #7's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Further review of the MDS assessment revealed the resident required extensive assistance of two (2) staff for ambulation.

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F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Review of Physical Therapy Evaluation and Plan of Treatment, dated 01/26/17, revealed Resident #7 is at risk for anxiety, decreased ability to return to prior level of assistance and further decline in function and falls. Interventions included resident uses front wheeled walker and wheelchair for mobility. Review of Comprehensive Care Plan for at Risk for Falls, dated 08/26/15, revealed interventions to use nonskid footwear. Review of the Therapy Treatment Note, dated 01/27/17, revealed Resident #7 was ambulating when his/her knees buckled and the resident fell to the floor landing on bilateral knees and bilateral hands to break fall. Review of the Radiology Report, dated 01/27/17 of left hand revealed an acute complete slightly displaced fracture involving the left fifth metacarpal shaft. No dislocation is seen. Mild diffuse soft tissue swelling is noted. Review of a Physician Order, dated 01/27/17, revealed an order to apply ice to left pinky finger as needed and appy splint to left pinky finger. Review of the facility Investigation, dated 01/27/17, related to Resident #7's 01/27/17 fall, revealed the facility determined the root cause of the fall was the resident's knee gave out while ambulating with therapy. In addition, review of a Coaching and Counseling Session documentation, dated 01/27/17, revealed PTA #1 was counseled related to the policy requiring all staff to use a gait belt while ambulating residents. Interview with Resident #7, on 02/07/17 at 2:15 PM, revealed he/she had fallen on 01/27/17 while ambulating with the physical therapy staff. The resident stated as they were coming out of therapy, he/she stubbed his/her foot on the carpet in the hall, fell , and hit his/her left hand sustaining a fractured 5th finger of left hand. The resident revealed the therapist did not have a gait belt on him/her which is what they always use. The resident further stated the Therapist was unable to ease him/her to the floor without the gait belt. Attempts to interview Physical Therapy Assistant, on 02/07/17 at 4:15 PM and 02/08/17 at 7:30 AM, were unsuccessful. Interview with the Manager of the Rehab Department and facility Administrator, on 02/08/17 at 10:30 AM, revealed Resident #7's fall on 01/27/17 probably could not have been prevented however they stated it was possible if the gait belt had been used, it may have prevented the injury of the fractured left 5th finger. They stated the facility's policy is for staff to use a gait belt during ambulation, transfer or movement of residents and the PTA should have used the gait belt.
F 0328 **Level of harm -** Actual harm **Residents Affected -** Few	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure one (1) of six (6) sampled residents (Resident #7) received care that was consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences related to [MEDICAL CONDITION]/[MEDICATION NAME] care. Resident #7 required his/her [MEDICAL CONDITION] bag to be changed; however, staff failed to change the [MEDICAL CONDITION] bag timely which resulted in the [MEDICAL CONDITION] bag becoming full and bursting off of the stoma with feces spilling over the resident and his/her bed on several occasions. Resident #7 stated he/she felt dirty and humiliated each time it happened. The findings include: Interview with the Administrator, on 02/07/17 at 2:30 PM revealed the facility did not have a policy to address [MEDICATION NAME]/[MEDICAL CONDITION] care but later produced a [MEDICAL CONDITION] check sheet for care that did not address how often the care should be done. Record review revealed the facility admitted Resident #7 on 08/15/15 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 12/09/16, revealed the facility assessed Resident #7's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Review of the Comprehensive Care Plan for Risk for complications related to [MEDICAL CONDITION] and [MEDICAL CONDITION], dated 08/30/16, revealed a goal to not have complications of ostomies without appropriate nursing interventions through next review date, and an intervention to change [MEDICAL CONDITION] bag and wafer as indicated. In addition, an intervention was added that Resident #7 prefers for the [MEDICAL CONDITION] bag to be changed instead of emptying when BM noted. Interview with Resident #7, on 02/07/17 at 2:15 PM, revealed he/she stated I can't get anyone to answer the call light. He/she further stated his/her [MEDICAL CONDITION] bag burst open two (2) days ago and stool went all over him/her because staff had not answered his/her call light. The resident stated, I had stool all over me and it was so humiliating and dirty. He/she further stated this has happened before and each time he/she had pressed the call light. Interview with Certified Nurse Aide (CNA) #1, on 02/08/17 at 6:05 AM, revealed she worked nights and could not get to Resident #7 before his/her [MEDICAL CONDITION] burst open. CNA #1 stated Resident #7 had his/her call light on and she was unable to get to the resident before it burst. She revealed she cleaned the resident up after the feces had spilled out and over the resident. She stated she can empty the [MEDICAL CONDITION] but could not change the bag. She stated the resident said his/her light had been on for a while and she couldn't get to him/her. Interview with Licensed Practical Nurse (LPN) #1, on 02/08/17 at 5:30 AM, revealed Resident #7 has had the [MEDICAL CONDITION] bag burst open recently but she was not sure of the date. She stated if the [MEDICAL CONDITION] bag is not emptied on time then the stool pushes the bag causing the wafer and bag to separate and potentially spilling feces onto the resident and bed. She revealed it had happened a few times because staff were not able to respond in time to change it and the incidents had happened in the last two (2) weeks. She stated the resident becomes very upset because the stool spills out on him/her. She becomes very anxious and his/her blood pressure increased. She stated licensed staff would stop and help the CNAs but even with helping them they could not answer all the lights. Interview with the Administrator, on 02/07/17 at 2:30 PM, revealed she was unaware of Resident #7's [MEDICAL CONDITION] bag bursting open but expected staff to change the [MEDICAL CONDITION] bag prior to the [MEDICAL CONDITION] becoming so full and to follow the Comprehensive Care Plan on changing the bag and emptying the bag as needed. She also revealed to ensure the resident's bag did not come off or burst, she expects all nursing staff who cares for resident to make every effort to ensure bag does not burst open. She also stated that accidents happen.
F 0353 **Level of harm -** Actual harm **Residents Affected -** Few	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility KRONOS Time Keeping System, it was determined the facility failed to ensure sufficient staff and related services to maintain the highest practicable physical, mental and psychosocial well-being of three (3) of nine (9) sampled residents (Resident #2, #6, and #7). The facility's failure to have sufficient staff caused Resident #2 to not be able to get up in the morning when he/she preferred; Resident #6 to have incontinent episodes due to not toileting timely which caused him/her to feel humiliated, dirty and ashamed and possibly contributed to his/her skin breakdown; and, caused Resident #7's [MEDICAL CONDITION] bag to burst open on several occasions due to not being emptied timely causing him/her to feel humiliated and dirty. Refer to F241, F282, F310, F314 and F328. The findings include: Interview with the Administrator, on 02/08/17 at 6:50 AM, revealed the staffing matrix she wanted for night shift was four to five Certified Nurse Aides (CNA) with two (2) licensed staff (Registered Nurse {RN} or Licensed Practical Nurse {LPN}. She stated she did not use an acuity based staffing program although one was available. Review of the KRONOS Time Keeping System used for this facility from 01/26/17 to 02/08/17 revealed CNA staffing for the hours from 11:00 PM to 7:00 AM were as follows: two (2) CNAs with one in orientation on 01/28/17, 01/29/17, 02/01/17, 02/06/17, and 02/07/17; three (3) CNAs on 01/26/17, 01/27/17, 01/31/17, 02/03/17, and 02/05/17; three (3) CNAs with one (1)

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	185340	A. BUILDING _____ B. WING _____	02/08/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF GLASGOW REHAB & WELLNESS C	220 WESTWOOD ST. GLASGOW, KY 42141

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0353 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) on orientation on 02/02/17; four CNA (4) with one CNA entering at 3:30 AM on 02/08/17; two CNAs with one (1) on orientation and one (1) entering at 3:00 AM on 01/30/17, and, five (5) CNAs and one (1) coming in at 4:00 AM on 02/04/17. Further review revealed there were two (2) licensed staff scheduled each night. Interview with the Administrator, on 02/08/17 at 11:00 AM, revealed the Director of Nursing and other staff came in to help on short staffed nights; however, review of the KRONOS Report for 01/27/17 through 02/08/17 revealed there was no documented evidence the DON worked any shifts at night. 1. Record review revealed the facility admitted Resident #2 on 03/04/16 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/03/16, revealed the facility assessed Resident #2's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Further review of the MDS assessment revealed the resident was a two (2) person assist for transfers. Interview with Resident #2, on 02/06/17 at 1:00 PM, revealed he/she was wheelchair bound with bilateral amputations and had to have assistance to move from bed to chair and back. He/she stated at around 5:00 AM to 6:00 AM, he/she wants to get out of bed and when he/she uses his/her call light, it sometimes takes a long time for someone to answer and can take till 7:00 AM when the next shift comes in to get out of bed. He/she stated he/she should be able to get out of the bed when he/she wants to. 2. Record review revealed the facility admitted Resident #6 on 10/21/15 with [DIAGNOSES REDACTED]. Resident #6 also has a Left [MEDICAL CONDITION] which was performed in 7/2016. Review of the Quarterly MDS assessment, dated 01/23/17, revealed the facility assessed Resident #6's cognition as intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Further review revealed the resident was continent of bowel and occasionally incontinent of bladder. Interview with Resident #6, on 02/07/26 at 3:30 PM, revealed he/she had to pee on myself multiple times due to staff not answering call lights on time. Resident #6 stated it happens mostly happens on night shift between the hours of 2:00 AM and 5:00 AM and takes as long as 45 minutes to over an hour for the call light to be answered. The resident further revealed he/she would not be incontinent if call lights were answered in a timely manner and he/she has called the nurses station by cell phone to reach the nurse and tell her he/she needs to go to the restroom. Resident #6 stated it makes him/her feel dirty, ashamed and humiliated when it happens which is at least five (5) times in a week. 3. Record review revealed the facility admitted Resident #7 on 08/15/15 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated 12/09/16, revealed the facility assessed Resident #7's cognition as intact with a BIMS score of 15 which indicated the resident was interviewable. Interview with Resident #7, on 02/07/17 at 2:15 PM, revealed it takes a long time to answer call lights especially between the hours of 2:00 AM and 4:00 AM. Resident #7 stated, I can't get anyone to answer the call light. He/she revealed it makes him/her feel anxious and the anxiety causes him/her to have chest pain. Resident #7 revealed his/her [MEDICAL CONDITION] bag burst open two (2) days ago and he/she had stool all over him/her. He/she stated it was so humiliating and he/she felt dirty. The resident revealed this has happened before. Interviews on 02/08/17 with Certified Nurse Aide (CNA) #1 at 6:05 AM and CNA #2 at 6:15 AM revealed there has only been two (2) CNA's on night shift this past week and it is impossible to care for sixty (60) residents, especially when there are multiple residents that require the assistance of two (2) staff. They stated it was impossible to answer the call light in a timely manner and residents may have to wait over an hour to get help. Interview with Licensed Practical Nurse (LPN) #1, on 02/08/17 at 5:00 AM revealed when there is less staff residents dont get the care they should. She further stated its happened a lot lately because of a staffing shortage. Interview with the Administrator and Director of Nursing (DON), on 02/08/17 at 3:30 PM, revealed they expected to have appropriate staffing to meet all the needs of the residents.
F 0490 **Level of harm** - Actual harm **Residents Affected** - Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility KRONOS Time Keeping System, it was determined the facility failed to ensure sufficient staff and related services to maintain the highest practicable physical, mental and psychosocial well-being of three (3) of nine (9) sampled residents (Resident #2, #6, and #7). The facility's failure to have sufficient staff caused Resident #2 to not be able to get up in the morning when he/she preferred; Resident #6 to have incontinent episodes due to not toileting timely which caused him/her to feel humiliated, dirty and ashamed and possibly contributed to his/her skin breakdown; and, caused Resident #7's [MEDICAL CONDITION] bag to burst open on several occasions due to not being emptied timely causing him/her to feel humiliated and dirty. Refer to F241, F282, F310, F314, F328, F353. The findings include: Interview with the Administrator, on 02/08/17 at 6:50 AM, revealed the staffing matrix she wanted for night shift was four to five Certified Nurse Aides (CNA) with two (2) licensed staff (Registered Nurse {RN} or Licensed Practical Nurse {LPN}. She stated she did not use an acuity based staffing program although one was available. Review of the KRONOS Time Keeping System used for this facility from 01/26/17 to 02/08/17 revealed CNA staffing for the hours from 11:00 PM to 7:00 AM were as follows: two (2) CNAs with one in orientation on 01/28/17, 01/29/17, 02/01/17, 02/06/17, and 02/07/17; three (3) CNAs on 01/26/17, 01/27/17, 01/31/17, 02/03/17, and 02/05/17; three (3) CNAs with one (1) on orientation on 02/02/17; four CNA (4) with one CNA entering at 3:30 AM on 02/08/17; two CNAs with one (1) on orientation and one (1) entering at 3:00 AM on 01/30/17, and, five (5) CNAs and one (1) coming in at 4:00 AM on 02/04/17. Further review revealed there were two (2) licensed staff scheduled each night. Interview with the Administrator, on 02/08/17 at 11:00 AM, revealed the Director of Nursing and other staff came in to help on short staffed nights; however, review of the KRONOS Report for 01/27/17 through 02/08/17 revealed there was no documented evidence the DON worked any shifts at night. 1. Record review revealed the facility admitted Resident #2 on 03/04/16 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/03/16, revealed the facility assessed Resident #2's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Further review of the MDS assessment revealed the resident was a two (2) person assist for transfers. Interview with Resident #2, on 02/06/17 at 1:00 PM, revealed he/she was wheelchair bound with bilateral amputations and had to have assistance to move from bed to chair and back. The resident stated at around 5:00 AM to 6:00 AM, he/she wants to get out of bed and when he uses his/her call light, it sometimes takes a long time for someone to answer and can take till 7:00 AM when next shift comes in to get out of bed. He/she stated he/she should be able to get out of the bed when he/she wants to. 2. Record review revealed the facility admitted Resident #6 on 10/21/15 with [DIAGNOSES REDACTED]. Resident #6 also has a Left [MEDICAL CONDITION] which was performed in 7/2016. Review of the Quarterly MDS assessment, dated 01/23/17, revealed the facility assessed Resident #6's cognition as intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Further review revealed the resident was continent of bowel and occasionally incontinent of bladder. Interview with Resident #6, on 02/07/16 at 3:30 PM, revealed he/she had to pee on myself multiple times due to staff not answering call lights on time. Resident #6 stated it happens mostly happens on night shift between the hours of 2:00 AM and 5:00 AM and takes as long as 45 minutes to over an hour for the call light to be answered. The resident further revealed he/she would not be incontinent if call lights were answered in a timely manner and he/she has called the nurses station by cell phone to reach the nurse and tell her he/she needs to go to the restroom. Resident #6 stated it makes him/her feel dirty, ashamed and humiliated when it happens which is at least five (5) times in a week. 3. Record review revealed the facility admitted Resident #7 on 08/15/15 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated 12/09/16, revealed the facility assessed Resident #7's cognition as intact with a BIMS score of 15 which indicated the resident was interviewable. Interview with Resident #7, on 02/07/17 at 2:15 PM, revealed it takes a long time to answer call lights especially between the hours of 2:00 AM and 4:00 AM. Resident #7 stated, I can't get anyone to answer the call light. The resident revealed it makes him/her feel anxious and the anxiety causes him/her to have chest pain. Resident #7 revealed his/her [MEDICAL CONDITION] bag burst open two (2) days ago and he/she had stool all over him/her. Resident #7 stated it was so humiliating and he/she felt dirty. The resident revealed this has happened before. Interviews on 02/08/17 with Certified Nurse Aide (CNA) #1 at 6:05 AM and CNA #2 at 6:15 AM revealed there has only been two (2) CNA's on night shift this past week and it is impossible to care for sixty (60) residents, especially when there are multiple residents that require the assistance of two (2) staff. They stated it was impossible to answer the call light in

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F 0490 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) a timely manner and residents may have to wait over an hour to get help. Interview with Licensed Practical Nurse (LPN) #1, on 02/08/17 at 5:00 AM revealed when there is less staff residents don't get the care they should. She further stated its happened a lot lately because of a staffing shortage. Interview with the Administrator and Director of Nursing (DON), on 02/08/17 at 3:30 PM, revealed they expected to have appropriate staffing to meet all the needs of the residents.