DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:7/6/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185340	(X2) MULTIPLE CONSTRUC A. BUILDING B. WING	CTION	(X3) DATE SURVEY COMPLETED 02/08/2017
NAME OF PROVIDER OF SU		1	STREET ADDRESS, CIT	TY, STATE, ZIP
SIGNATURE HEALTHCAR	E OF GLASGOW REHAB & W	ELLNESS C	220 WESTWOOD ST. GLASGOW, KY 42141	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing ho		cy.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		IENCY MUST BE PRECEI	DED BY FULL REGULATORY
F 0241	Provide care for residents in a v	vay that keeps or builds each r	esident's dignity and	
Level of harm - Actual harm	respect of individuality. **NOTE- TERMS IN BRACKET Based on interview, record review residents in a manner and in an et	v and facility policy review, it want in the maintains/enhar	as determined the facility fai aces resident's dignity and re	iled to promote care for spect in full recognition of
F 0282 Level of harm - Actual	residents in a manner and in an ethis/her individuality, and refrain Resident #7). The facility failed to empty Resid CONDITION] bag bursting open and spilling fe- facility failed to toilet Resident # made him/her feel dirty, ashamed The findings include: Review of the policy titled, Resid respect, and dignity. Residents ar facility will make every effort to treated with respect, kindness, an 1. Record review revealed the fac Resident #6 also has a Left [MEI] Set (MDS) assessment, dated 01/23/1 of Mental Status (BIMS) score of assessment revealed the resident Interview with Resident #6, on 02 answering call lights on time. Th AM. The resident revealed it take resident stated he/she would not 1 nurses station by cell phone to re makes him/her feel dirty, ashame Interviews on 02/08/17 with Certi (2) CNA's on night shift this past multiple residents that require the a timely manner and residents multiple from his/her cell phone to let her #6's room cannot be seen from th staff go through the double doors by staff so Resident #6 often has 2. Record review revealed the face MDS assessment, dated 12/916 i (15) which indicated the resident Interview with Resident #7 on 02 between the hours of 2:00 AM ar stated it makes him/her feel anxit CONDITION] bag burst open tw light. The resident stated, I had st happened before. Interview with Certified Nurse Ai Resident #7 before his/her [MED] unable to get to the resident befor over the resident. She stated she os aid his/her light had been on for Interview with Certified Nurse Ai Resident #7 before his/her [MED] unable to get to the resident befor over the resident. She stated she os aid his/her light had been on for interview with Licensed Practical CONDITION] bag burst open rec emptied on time then the stool pu resident and bed. She revealed it the incidents had happened in the out on him/her. She becomes ver emptied on time then the stool pu resident and bed. She revealed it the incidents had happened in the out on him/her. She becomes ver emptis to be kept as clean a rig	nvironment that maintains/enhar from practices demeaning to two ent #7's [MEDICAL CONDITIO ces on the resident. Resident #7 6 in a timely manner to prevent 1 and humiliated. ent Rights, not dated, revealed e e entitled to exercise their rights assist each resident in exercising d dignity. ility admitted Resident #6 on 10 DICAL CONDITION] which wa 17, revealed the facility assessed f fifteen (15) which indicated the/ was continent of bowel and occ: /07/26 at 3:30 PM, revealed he/ e resident stated it mostly happe es forty-five (45) minutes to over be incontinent if call lights were ach the nurse and tell her he/she d and humiliated when it happer fied Nurse Aide (CNA) #1 at 63 week and it is impossible to car e assistance of two (2) staff. The assistance of two (2) staff. The y have to wait over an hour to g Nurse (LPN) #1, on 02/08/17 at know that he/she needs to urina e hallway as the hall has a doub s, the light cannot be seen. She st incontinent accidents. ility admitted Resident #7 on 08 revealed the facility assessed Re t was interviewable. /07/17 at 2:15 PM revealed it tak d 4:00 AM. The resident stated, ous and the anxiety causes me to o (2) days ago and stool went at tool all over me and it was so hu de (CNA) #1, on 02/08/17 at 6:0 ICAL CONDITION] burst oper re it burst. She revealed she clea can empty the [MEDICAL CON a while and she couldn't get to F Nurse (LPN) #1, on 02/08/17 at 6:0 ICAL CONDITION] burst oper re it burst. She revealed she clea can empty the [MEDICAL CON a while and she couldn't get to f Nurse (LPN) #1, on 02/08/17 at 6:0 ICAL CONDITION] burst oper re it burst. She revealed she clea can empty the [MEDICAL CON a while and she couldn't get to f Nurse (LPN) #1, on 02/08/17 at 6:0 ICAL CONDITION] burst oper re at burst. She revealed she clea can empty the [MEDICAL CON a while and she couldn't get to f Nurse (LPN) #1, on 02/08/17 at 6:0 ICAL CONDITION] burst oper re it burst. She revealed she clea can empty the [MEDICAL CON a while and she couldn't get to f Nurse (LPN) #1, on 02/08/17 at	aces resident's dignity and re (2) of six (6) sampled resid DN] bag in a timely manner stated it was so humiliating incontinent episodes. Reside mployees shall treat all resid and privileges to the fullest is performed in July 2016. R Resident #6's cognition as i resident was interviewable usionally incontinent of blad she had to pee on myself mu- needs to go to the restroom. Is which is at least five (5) t DS AM and CNA #2 at 6.15 to 20 AM, revealed Resider te. She stated the call light to and CNA #2 at 6.15 5:00 AM, revealed Resider te. She stated the call light a le doorway that obstructs the ate doorway that obstructs the ate dathere is no audible call /15/15 with [DIAGNOSES] sident #7's cognition as intac tes a long time for staff to an I can't get anyone to answer have chest pain. He/she fur lover him/her because staff miliating and dirty. He/she fur is stated it call resident we thave the stated the call light a le dathere is no audible call /15/15 with [DIAGNOSES] sident #7's cognition as intac tes a long time for staff to an I can't get anyone to answer have chest pain. He/she fur lover him/her because staff miliating and dirty. He/she fur staff were not able to resy he resident up after the DITION] but could not chan im/her. .5:30 AM, revealed Resider e date. She stated if the [ME and bag to separate and pote te staff were not able to resy he resident becomes very up sure increased. She stated li to resy he resident becomes very up sure increased. She stated li to cover he tresident becomes very up sure increased. She stated li the [ME and bag to separate and pote e to the incontinent if it cover heresident becomes very up sure increased. She stated li the Restreased. She stated li the Restreased. She stated li the Restreased. She stated li the Restreased. She stated li the and bag to separate and pote the resident becomes very up sure increased. She stated li the staff were not able to resy he resident becomes very up sure increased.	spect in full recognition of lents (Resident #6 and resulting in the [MEDICAL and dirty. In addition, the ent #6 stated the incidents lents with kindness, extent possible. The the resident is always REDACTED]. Further review revealed eview of the Quarterly Minimum Data ntact with a Brief Interview . Further review of the MDS der. litiple times due to staff not e hours of 2:00 AM and 5:00 be answered at night. The er and he/she has called the Resident #6 stated it imes a week. AM revealed there has only been two pecially when there are answer the call light in at #6 often calls her from the room bove the door on Resident e view of the light and unless system that can be heard REDACTED]. Review of the Quarterly et with a BIMS score of fifteen answer call lights especially r the call light. The resident ther revealed his/her call urther stated it has an ights and could not get to 7 had his/her call light on and she was feces had spilled out and nge the bag. She stated the resident the 7 has had the [MEDICAL DICAL CONDITION] bag is not nitially spilling feces onto the poond in time to change it and uset because the stool spills censed staff would stop and vealed they expected call lights uld be prevented and everyone f to respect residents'
<ul> <li>Level of harm - Actual harm</li> <li>Based on interview, record review, and facility policy and procedure review, it was determined the facility failed to follo the plan of care for two (2) of six (6) sampled residents (Resident #6 and #7).</li> <li>Residents Affected - Few</li> <li>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.</li> <li>Resident #7 was care planned to change [MEDICAL CONDITION] bag timely to prevent the [MEDICAL CONDITION] bag from burstin stoma and feeces to pour on to the resident. This caused the resident to feel dirty and humiliated. The findings include:</li> </ul>				has the urge to urinate ent could be toileted to d; however, the facility staff failed to
LABORATORY DIRECTOR REPRESENTATIVE'S SIGN	S OR PROVIDER/SUPPLIER	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.

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER / SUPPLIER / CLIA       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NUMBER       B. WING       02/08/2017         NAME OF PROVIDER OF SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP	DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:7/6/2017 FORM APPROVED OMB NO. 0938-0391
SIGNATURE LIALTICATE OF CLASGOW RELIAE & WILLARSS (	DEFICIENCIES AND PLAN OF CORRECTION	À CLIA IDENNTIFICATION NUMBER 185340	À. BUILDING	TION	(X3) DATE SURVEY COMPLETED
Old ID DRETN TAG         ILMMARY STATEMENT OF DEFICIENCIS EACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY           F023         Cortismed_from page 1)         Cortismed_from page 1)           Ever of ham - Annual harm         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1)           Reidens Affectol - From page 1)         Cortismed_from page 1)         Cortismed_from page 1) <td></td> <td></td> <td>ELLNESS C</td> <td>220 WESTWOOD ST.</td> <td>ATE, ZIP</td>			ELLNESS C	220 WESTWOOD ST.	ATE, ZIP
Level of harm-Acult         Review of facility info; inted. Care Plun. Comprehensive, policy statement revealed an institutionation any synchrogical policy information. The information in the informatin the inthe inthe information in the informatin the information i		SUMMARY STATEMENT OF I	DEFICIENCIES (EACH DEFICI		FULL REGULATORY
Level of harm - Actual harm       miless unavoidable.       TextRMS 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 resident' abilities in toileting do not diminish for one (1) of six (6) sampled residents (Resident #6).         Resident 5 Affected - Few       Resident #6 was assessed as continent of bould the casis of the resident to have incontinent episodes. Resident #6 wasted it made him her feel diry, ashamed and humiliated when it happens which is at least five (5) times a week         The findings include:       Review of the facility 5 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 antitted 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 anderseak Resident #6 is orgition as intact with a Brief Interview of Mental Status (BIMS) score of fiften (15) which indicated the resident was interviewable. Fur	Level of harm - Actual harm	(continued from page 1) Review of facility policy titled, Ci plan that includes measurable obj needs is developed for each resid comprehensive care plan for each attain. The comprehensive care p responsible party as indicated. Record review revealed the faciliti [MEDICAL CONDITION] whici [01/23/17, revealed the facility ass score of fifteen (15) which indica Review of Resident #6's Compreh weakness, history of [MEDICAL encourage the resident to ask for assistance a Resident #6, on 02/07/16 at 3:30 call lights on time. Resident #6 st it takes as long as forty-five (45) revealed he/she has called the nur restroom. The resident stated it ha am dirty and embarrassed. Interviews on 02/08/17 with Certi his/her call light when he/she nee call light timely to toilet the resid only two (2) CNAs and revealed Interview with Licensed Practical often calls her from the room from light above the door on Resident the view of the light and unless st audible call system that can be he 2. Record review revealed the faci MDS assessment, dated 12/09/16 fifteen (15) which indicated the ra Review of the Comprehensive Ca CONDITION], dated 08/30/16, revealed a goal to next review date, and an interven Resident #7, on 02/07/17 at 2:15 had stool all over me and it has h- bag was not emptied in time befo times. He/she stated each time he burst open. Interview with LICNA #1, on 02/08, [MEDICAL CONDITION] burst resident before i burst. She revea She stated she can empty the [MF had been on for a while and she c Interview with LPN #1, on 02/08, but she was not sure of the date. S to change it and the incidents had the stool spills out on him/her ans staff would stop and help the CN. Interview with the Administrator at	are Plans-Comprehensive, policy jectives and timetables to meet th ent. The Guideline #1 states the 1 resident that identifies the highe lan will be developed with partic y admitted Resident #6 on 10/21. h was performed in 7/2016. Revi sessed Resident #6's cognition as ted the resident was interviewable ensive Care Plan for risk for tota . CONDITIONS] and [MEDICA] as soon as he/she has the urge to PM, revealed he/she has had to p ated it happens mostly on night s minutes to over an hour for the c rses station by cell phone to reacl appens at least five (5) times in a fied Nurse Aide (CNA) #1 at 6:0 dis to be toileed. They stated the elent. They stated staff cannot anss residents may have to wait over a Nurse (LPN) #1, on 02/08/17 at m his/her cell phone to let her km #6's room cannot be seen from th taff go through the double doors, ard by staff so Resident #6 often lity admitted Resident #7 on 08/ i, revealed the facility assessed Re esident was interviewable. re Plan for Risk for complication o not have complications of ostor tion to change the [MEDICAL C PM, revealed the call light and /17 at 6:05 AM, revealed she woo open. CNA #1 stated Resident #1 ded she cleaned the resident up a EDICAL CONDITION] but could right to thim/her. 117 at 5:30 AM, revealed Resident #10 to couldn't get to him/her.	e resident's medical, nursing, ment Nurse/Interdisciplinary Team devel is level of functioning the resident ipation from the resident, resident's /15 with [DIAGNOSES REDACT] ew of the Quarterly Minimum Data intact with a Brief Interview of Me e. 1 loss of bladder and bowel control L CONDITION], dated 04/29/15, r urinate and/or defecate. However, i ee on myself multiple times due to hift between the hours of 2:00 AM all light to be answered. The reside n the nurse and tell her he/she need week and makes him/her feel like 5 AM, and CNA #2 at 6:15 AM, re resident is continent as long as stal wer call lights in a timely manner d in hour to get help. 5:00 AM, revealed Resident #6 is n ow that he/she needs to urinate. She the hallway as the hall has a double of the light cannot be seen. She stated has incontinent accidents. 15/15 with [DIAGNOSES REDAC] esident #7's cognition as intact with s related to [MEDICAL CONDITI nies without appropriate nursing in ONDITION] bag and wafer as indi MEDICAL CONDITION] bag bu was so humiliating and dirty. The r ed it happens on night shift and has in oone had answered before the [] rked nights and could not get to Re 7 had his/her call light on and she v ofter the feces had spilled out and ov firet feces had spilled out and ov firet heces had spilled out and ov firet heces had spilled out and ov firet heces had spilled out and so w firet heces had spilled out and yo the the faces had spilled out and yo firet heces had spilled out and yo firet heces had spilled out and yo firet he faces had spilled out and yo firet heces had spilled out and yo w firet heces had spilled out and yo firet heces had spilled o	al and psychological ops and maintains a may be expected to a family and/or ED]. Resident #6 also has a Left a Set (MDS) assessment, dated ental Status (BIMS) related to muscle evealed an intervention to interview with staff not answering the and 5:00 AM because ant further s to go to the no one cares and I evealed Resident #6 uses ff can answer the ue to there being normally continent and e stated the call doorway that obstructs I there is no TED]. Review of the Quarterly a BIMS score of ON] and [MEDICAL terventions through icated. However, interview with st open two (2) days ago and I esident stated the s happened a few MEDICAL CONDITION] bag sident #7 before his/her was unable to get to the ver the resident. e resident said his/her light DITION] bag burst open recently e to respond in time s very upset because he stated licensed
Residents Affected - Few       In a 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 1021/15 with [DIAGNOSES REDACTED]. Further review revealed Resident #6 also has a Left [MEDICAL CONDITION] which was performed in July 2016. Review of the Muster work 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, Nurse Aide Care Plan (at 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	Level of harm - Actual	unless unavoidable. **NOTE- TERMS IN BRACKET	IS HAVE BEEN EDITED TO P	ROTECT CONFIDENTIALITY**	
FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185340 If continuation sheet		facility failed to provide appropri for one (1) of six (6) sampled resi Resident #6 was assessed as conti for toileting: however, staff failer incontinent episodes. Resident #6 least five (5) times a week The findings include: Review of the facility's Lippincott commode, Incontinence Manager a disease nor a part of normal agi offered frequently-before meals, ' procedures. Using a commode is elimination posture which aids in Record review revealed the facilit Resident #6 also has a Left [MEI] Set (MDS) assessment, dated 01/23/1 of Mental Status (BIMS) score of assessment, revealed the resident Review of the Comprehensive Ca per schedule and an intervention, Care Plan, dated 05/30/14, reveal 01/31/17, to use bedside commod Interview with Resident #6, on 02 answering call lights on time. The AM. The resident revealed it take resident stated he/she would not furvise with Certified Nurse Ai stated there was only two (2) CN, residents timely especially when call lights in a timely manner and was continent if the resident recei Interview with CNA #2, on 02/08, stated it is impossible to get arout	ate treatment and services to ensi- idents (Resident #6), nent of bowel and occasionally in 1 to toilet the resident in a timely is stated it made him/her feel dirty t's Nursing Procedures Fifth Editi- ment, and Correcting Urinary Inc. ng. Incontinence may be caused visiting hours, during morning ar an alternative to a bedpan. The b defecation. y admitted Resident #6 on 10/21. DICAL CONDITION] which was 17, revealed the facility assessed if fifteen (15) which indicated the was continent of bowel and occa re Plan for at risk for skin compr dated 01/31/17, to utilize bedsid ed an update, dated 06/03/14, to /07/16 at 3:30 PM, revealed he/s e resident stated it mostly happen es forty-five (45) minutes to over be incontinent if call lights were a ach the nurse and tell her he/she ned and humiliated when it happ de (CNA) #1, on 02/08/17 at 6:0 A's and two (2) licensed staff this there are multiple residents that rt revealed residents may have to vived help to the bathroom or a be (17 at 6:15 AM, revealed she was nd to everyone for turning, chang	are residents' abilities in toileting d neontinent of bladder and required manner which caused the resident , ashamed and humiliated when it l ion regarding Bedpan and Urinal M ontinence with bladder retraining r by restricted mobility. Bedpan and id evening care, and at the time of i edpan allows the patient to assume /15 with [DIAGNOSES REDACTI s performed in July 2016. Review of Resident #6's cognition as inact wi resident was interviewable. Furthe isionally incontinent of bladder. omises, dated 04/29/15, revealed an e commode at night. Review of Re toilet upon rising and at bedtime, a he had to pee on myself multiple ti is on night shift between the hours answered in a timely manner and h spast week and it is impossible to equire two (2) assist. She revealed wait over an hour to get help. She r d pan in time.	o not diminish the assistance of staff to have happens which is at lanagement, using a evealed incontinence is not urinal should be any treatments or his/her normal ED]. Further review revealed of the Quarterly Minimum Data ith a Brief Interview r review of the MDS h intervention to toilet sident #6's Nurse Aide and an update, dated mes due to staff not of 2:00 AM and 5:00 vered at night. The e/she has called the h #6 further stated t week. nights most nights. CNA #1 veekal Resident #6 o with residents. CNA #2 d when there is

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NAME OF PROVIDER OF SU SIGNATURE HEALTHCAR				
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state su		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			
F 0310	(continued from page 2)	esident #6's was normally continent but when it ta	alize too long to any use the call light due	
Level of harm - Actual harm	to not enough staff the resident is	incontinent.	<u> </u>	
Residents Affected - Few	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 hall way 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 as continent as possible.)			
F 0314	Cive residents proper treatmen	t to prevent new bed (pressure) sores or heal ex	zisting hed	
Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	sores. **NOTE- TERMS IN BRACKET Based on observation, interview, failed to ensure one (1) of six (6) not develop pressure sores. Resident #6 was identified as hav exudate and sloughing on 02/01/	TS HAVE BEEN EDITED TO PROTECT CONF record review, and facility policy and procedure re sampled residents (Resident #6), who entered the ing a Suspected Deep Tissue Injury on the right bu 17 with Physician's Orders received to apply [ME]	IDENTIALITY** eview, it was determined the facility facility without pressure sores did uttock and a coccyx wound with green DICATION NAME/Criticaid cream 1:1 ratio	
	<ul> <li>I opically 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.</li> <li>The findings include:</li> <li>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, and education and quality improvement.</li> <li>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</li> <li>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 MS assessment revealed the resident was 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 beeding and review of the Certified Nurse Aide Care Plan, dated 05/30/14, revealed to toilet upon at be dime and to turn and reposition every two (2) hours and as</li> </ul>			
	Tissue Injury (SDTI) was identifi and an area to coccyx was descril Review of Initial Weekly Wound with no depth to right buttock and green exudate and a mild odor, h Review of a Physician Order, date coccyx and right buttock two (2) Review of the Comprehensive Ca to use bedside commode due to f buttock two (2) times a day (BID Review of the February 2017 Mec Observation of Resident #6's Wot 10:00 AM, revealed she determin incontinence of urine and feces w the APRN told the resident that s his/her wound at any time. The a 0.8 cm x 0.1 cm unstageable and 3.0 cm x 0.2 cm, described as um interview with Resident #6, on 02 answering the call light timely an minutes to over an hour for the cc if call lights were answered in a t and tell her he/she needs to go to for two (2) days because it was n the next day. Interview with Licensed Practical she had applied it the night of 02, was unable to provide an explana Interview with Director of Nursin	re Plan for Impaired Skin Integrity, dated 01/30/1 riction from bedpan at night and to apply Silvadin lo wound. dication Administration Record [REDACTED]. and Assessment conducted by Advanced Practice ed the wounds were caused from pressure resultir rould inhibit healing of the wounds and potentially he would be cleaning the wound first before asses seessment revealed the pressure sores had worsen described as slough. green in color and the right b	Lit was described as a dark purple area, ands were identified. asuring five (5) by three (3) centimeters (cm) identified and described as having slough, AME]/Criticaid cream 1:1 ratio topically to the 7, revealed an intervention dated 01/31/17 e/Criticaid cream to coccyx and right Registered Nurse (APRN) #1, on 02/08/17 at 1g from a deep tissue injury. She stated y cause the wounds to become worse. When sing, the resident stated no one cleaned ed as the sacral measurements were 0.8 cm x buttock wound measurements were 0.8 cm x to tipicodes on nights due to staff not ent stated it takes forty-five (45) aled he/she would not be incontinent tion by cell phone to reach the nurse ation had been applied to his/her wounds her it was ordered and would be here ident #6's medication had been replaced and tion for two (2) and a half days. She ealed they expected staff to provide	
F 0323 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing hon supervision to prevent avoidable **NOTE- TERMS IN BRACKET Based on interview, record review one (1) of six (6) sampled residen accidents. On 01/27/17, the Physical Therap when the resident tripped and fell The findings include: Review of facility policy titled, Fa residents with assistance and sup Review of the facility Gait Belt P. shall sign an agreement regarding belt during ambulation, transfer of Step #12 revealed how to control body with the belt and gently and Record review revealed the facility Minimum Data Set (MDS) assess Brief Interview of Mental Status	te area is free from accident hazards and risks le accidents IS HAVE BEEN EDITED TO PROTECT CONF y and facility policy and procedure review, it was its (Resident #7) received adequate supervision ar y Assistant (PTA) was ambulating Resident #7 wi to the floor sustaining a fracture to his/her left 5t all Policy, last reviewed 06/01/15, revealed it is th ervision in an effort to minimize the risk of falls a blicy, last revised March 2011, revealed each emp g our Gait Belt protocol. Each employee who prov or movement of residents. In addition, under Educa a fall: If resident begins to fall, use the gait belt to slowly lower the resident to the floor by allowing y admitted Resident #7 on 08/15/15 with [DIAGN ment, dated 12/09/16, revealed the facility assess. (BIMS) score of fifteen (15) which indicated the revealed the resident required extensive assistance of	IDENTIALITY** determined the facility failed to ensure d assistance devices to prevent ithout using a gait belt per facility policy h finger. e intent of this facility to provide nd fall related injuries. bloyee who provides direct resident care rides direct resident care shall use a gait ational Guidelines, gait belts Procedural o draw the resident close to your g him/her to slide down your leg. VOSES REDACTED]. Review of the Quarterly ed Resident #7's cognition as intact with a resident was interviewable. Further	
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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:7/6/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/08/2017
NAME OF PROVIDER OF SU SIGNATURE HEALTHCAR	IPPLIER E OF GLASGOW REHAB & WI		
For information on the nursing (X4) ID PREFIX TAG	SUMMARY STATEMENT OF I	cy, please contact the nursing home or the state su DEFICIENCIES (EACH DEFICIENCY MUST BI	irvey agency.
F 0323	OR LSC IDENTIFYING INFORM (continued from page 3)		
Level of harm - Minimal harm or potential for actual harm	decreased ability to return to prio resident uses front wheeled walked dated 08/26/15, revealed interven		n and falls. Interventions included chensive Care Plan for at Risk for Falls,
Residents Affected - Few	resident fell to the floor landing of Review of the Radiology Report, the left fifth metacarpal shaft. No Order, dated 01/27/17, revealed a Review of the facility Investigatio determined the root cause of the 4 of a Coaching and Counseling Se requiring all staff to use a gait be Interview with Resident #7, on 02 physical therapy staff. The reside in the hall, fell, and hit his/her le therapist did not have a gait belt unable to ease him/her to the floor Attempts to interview Physical TF Interview with the Manager of the #7's fall on 01/27/17 probably co used, it may have prevented the i	/07/17 at 2:15 PM, revealed he/she had fallen on ( nt stated as they were coming out of therapy, he/s ft hand sustaining a fractured 5th finger of left har on him/her which is what they always use. The res	plete slightly displaced fracture involving ing is noted. Review of a Physician and appy splint to left pinky finger. 17 fall, revealed the facility ting with therapy. In addition, review 'A #1 was counseled related to the policy D1/27/17 while ambulating with the he stubbed his/her foot on the carpet nd. The resident revealed the ident further stated the Therapist was 08/17 at 7:30 AM, were unsuccessful. 10/20/8/17 at 10:30 AM, revealed Resident t was possible if the gait belt had been he facility's policy is for staff to
F 0328		ing special services, including: injections, colos	
Level of harm - Actual harm	care, and prostheses	tomy care, tracheal suctioning, respiratory care	,
Residents Affected - Few	**NOTE- TERMS IN BRACKET Based on interview and record rev (Resident #7) received care that v care plan, and the resident's goals Resident #7 required his/her [ME] CONDITION] bag timely which resulted in the over the resident and his/her bed happened. The findings include: Interview with the Administrator, NAME]/[MEDICAL CONDITION] how often the care should be done. Record review revealed the facilit Minimum Data Set (MDS) assess Brief Interview of Mental Status Review of the Comprehensive Ca CONDITION], dated 08/30/16, revealed a goal to next review date, and an interven intervention was added that Resi noted. Interview with Resident #7, on 02 He/she further stated his/her [MED unable to get to the resident bs/ner cal dirty. He/she further stated this/her [MED unable to get to the resident befor interview with Licensed Practical CONDITION] bag burst open rec emptied on time then the stool pu resident and bed. She revealed in the out on him/her. She becomes ver help the CNAs but even with helj Interview with the Administrator, bursting open but expected staff t full and to follow the Comprehensive the resident's bag did not come of	/07/17 at 2:15 PM, revealed he/she stated I can't g DICAL CONDITION] bag burst open two (2) day 1 light. The resident stated, I had stool all over me as happened before and each time he/she had press (e (CNA) #1, on 02/08/17 at 6:05 AM, revealed s ICAL CONDITION] burst open. CNA #1 stated I e it burst. She revealed she cleaned the resident u can empty the [MEDICAL CONDITION] but cou a while and she couldn't get to him/her. Nurse (LPN) #1, on 02/08/17 at 5:30 AM, revealed shes the bag causing the wafer and bag to separat had happened a few times because staff were not a last two (2) weeks. She stated the resident becom y anxious and his/her blood pressure increased. Sh ping them they could not answer all the lights.	e one (1) of six (6) sampled residents ice, the comprehensive person-centered ION]/[MEDICATION NAME] care. er, staff failed to change the [MEDICAL I bursting off of the stoma with feces spilling It dirty and humiliated each time it not have a policy to address [MEDICATION TION] check sheet for care that did not address IOSES REDACTED]. Review of the Quarterly ed Resident #7's cognition as intact with a esident was interviewable. DICAL CONDITION] and [MEDICAL ropriate nursing interventions through d wafer as indicated. In addition, an bag to be changed instead of emptying when BM get anyone to answer the call light. ys ago and stool went all over him/her because e and it was so humiliating and sed the call light. he worked nights and could not get to Resident #7 had his/her call light on and she was p after the feces had spilled out and ld not change the bag. She stated the resident ed Resident #7 has had the [MEDICAL if the [MEDICAL CONDITION] bag is not e and potentially spilling feces onto the able to respond in time to change it and les very upset because the stool spills ne stated licensed staff would stop and re of Resident #7's [MEDICAL CONDITION] bag r to the [MEDICAL CONDITION] bag on bag as needed. She also revealed to ensure
F 0353 Level of harm - Actual harm Residents Affected - Few	being. **NOTE- TERMS IN BRACKET Based on interview, record review failed to ensure sufficient staff an psychosocial well-being of three The facility's failure to have suffic preferred; Resident #6 to have ind dirty and ashamed and possibly c burst open on several occasions d F241, F282, F310, F314 and F32 The findings include: Interview with the Administrator, to five Certified Nurse Aides (CN She stated she did not use an actu Review of the KRONOS Time Ke hours from 11:00 PM to 7:00 AM	every resident in a way that maximizes the resilence of the facility KRONOS Time Keepid related services to maintain the highest practices of the facility KRONOS Time Keepid related services to maintain the highest practice of the staff caused Resident #2 to not be able to get contributed to his/her skin breakdown; and, caused ue to not being emptied timely causing him/her to 8. on 02/08/17 at 6:50 AM, revealed the staffing ma (A) with two (2) licensed staff (Registered Nurse ty based staffing program although one was availy eping System used for this facility from 01/26/17 (Were as follows: two (2) CNAs with one in orien CNAs on 01/26/17, 01/27/17, 01/31/17, 02/03/17	IDENTIALITY** ng System, it was determined the facility ble physical, mental and , and #7). up in the morning when he/she ch caused him/her to feel humiliated, Resident #7's [MEDICAL CONDITION] bag to o feel humiliated and dirty. Refer to trix she wanted for night shift was four {RN} or Licensed Practical Nurse {LPN}. able. to 02/08/17 revealed CNA staffing for the tation on 01/28/17, 01/29/17, 02/01/17,
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CENTERS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:7/6/2017 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/08/2017		
	AME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP				
SIGNATURE HEALTHCAR	IGNATURE HEALTHCARE OF GLASGOW REHAB & WELLNESS C 220 WESTWOOD ST. GLASGOW, KY 42141				
For information on the nursing (X4) ID PREFIX TAG	1	cy, please contact the nursing home or the s DEFICIENCIES (EACH DEFICIENCY MI	tate survey agency. ST BE PRECEDED BY FULL REGULATORY		
	OR LSC IDENTIFYING INFORM				
F 0353 Level of harm - Actual harm Residents Affected - Few	and one (1) entering at 3:00 AM or review revealed there were two (2 11:00 AM, revealed the Director KRONOS Report for 01/27/17 th 1. Record review revealed the faci Minimum Data Set (MDS) assess Brief Interview of Mental Status review of the MDS assessment re Interview with Resident #2, on 02	on 01/30/17, and, five (5) CNAs and one (1) 2) licensed staff scheduled each night. Inter- of Nursing and other staff came in to help o rough 02/08/17 revealed there was no docu lity admitted Resident #2 on 03/04/16 with ment, dated 11/03/16, revealed the facility (BIMS) score of fifteen (15) which indicate vealed the resident was a two (2) person as /06/17 at 1:00 PM, revealed he/she was who			
	of bed and when he/she uses his/l AM when the next shift comes in wants to. 2. Record review revealed the faci Left [MEDICAL CONDITION] the facility assessed Resident #6's interviewable. Further review rev Interview with Resident #6, on 02 answering call lights on time. Rei 5:00 AM and takes as long as 45 he/she would not be incontinent i cell phone to reach the nurse and dirty, ashamed and humiliated wf 3. Record review revealed the faci MDS assessment, dated 12/09/16 which indicated the resident was Interview with Resident #7, on 02 the hours of 2:00 AM and 4:00 A him/her feel anxious and the anxi bag burst open two (2) days ago a dirty. The resident revealed this h Interviews on 02/08/17 with Certi (2) CNA's on night shift this past multiple residents that require the a timely manner and residents ma Interview with Licensed Practical get the care they should. She furti	her call light, it sometimes takes a long time to get out of bed. He/she stated he/she shot lity admitted Resident #6 on 10/21/15 with which was performed in 7/2016. Review of cognition as intact with a BIMS score of fi ealed the resident was continent of bowel ar /07/26 at 3:30 PM, revealed he/she had to p sident #6 stated it happens mostly happens c minutes to over an hour for the call light to f call lights were answered in a timely mant tell her he/she needs to go to the restroom. I ten it happens which is at least five (5) time lity admitted Resident #7 on 08/15/15 with , revealed the facility assessed Resident #7's interviewable. /07/17 at 2:15 PM, revealed it takes a long t M. Resident #7 stated, I can't get anyone to ety causes him/her to have chest pain. Resid cut he/she had stool all over him/her. He/sh as happened before. fied Nurse Aide (CNA) #1 at 6:05 AM and week and it is impossible to care for sixty ( assistance of two (2) staff. They stated it w y have to wait over an hour to get help. Nurse (LPN) #1, on 02/08/17 at 5:00 AM r her stated its happened a lot lately because of and Director of Nursing (DON), on 02/08/17	for someone to answer and can take till 7:00 Id be able to get out of the bed when he/she [DIAGNOSES REDACTED]. Resident #6 also has a the Quarterly MDS assessment, dated 01/23/17, revealed freen (15) which indicated the resident was nd occasionally incontinent of bladder. ee on myself multiple times due to staff not in night shift between the hours of 2:00 AM and be answered. The resident further revealed ter and he/she has called the nurses station by Resident #6 stated it makes him/her feel s in a week. [DIAGNOSES REDACTED]. Review of the Quarterly cognition as intact with a BIMS score of 15 ime to answer call lights especially between answer the call light. He/she revealed it makes lent #7 revealed his/her [MEDICAL CONDITION] e stated it was so humiliating and he/she felt CNA #2 at 6:15 AM revealed there has only been two 60) residents, especially when there are as impossible to answer the call light in evealed when there is less staff residents dont		
F 0490 Level of harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRAČKET Based on interview, record review failed to ensure sufficient staff an psychosocial well-being of three. The facility's failure to have suffic preferred; Resident #6 to have ind dirty and ashamed and possibly c burst open on several occasions d f241, F282, F310, F314, F328, F The findings include: Interview with the Administrator, to five Certified Nurse Aides (CN She stated she did not use an acui Review of the KRONOS Time Kc hours from 11:00 PM to 7:00 AM 02/06/17, and 02/07/17; three (3) on orientation on 02/02/17; four ( and one (1) entering at 3:00 AM review revealed there were two ( 11:00 AM, revealed the Director KRONOS Report for 01/27/17 th 1. Record review revealed the faci Minimum Data Set (MDS) assess Brief Interview of Mental Status review of the MDS assessment re Interview with Resident #2, on 02 to have assistance to move from I 7:00 AM when next shift comes i wants to. 2. Record review revealed the faci Left [MEDICAL CONDITION] the facility assessed Resident #6, on 02 answering call lights on time. Ree 5:00 AM and takes as long as 45 he/she would not be incontinent i cell phone to reach the nurse and dirty, ashamed and humiliated wf 3. Record review revealed the faci MDS assessment, dated 12/09/16 which indicated the resident was Interview with Resident #7, on 02 the hours of 2:00 AM and 4:00 A makes him/her feel anxious and ti CONDITION] bag burst open tw and he/she felt dirty. The resident Interviews on 02/08/17 with Certi (2) CNA's on night shift this past	d related services to maintain the highest pr (3) of nine (9) sampled residents (Resident i cient staff caused Resident #2 to not be able continent episodes due to not toileting timel ontributed to his/her skin breakdown; and, c ue to not being emptied timely causing him 353. on 02/08/17 at 6:50 AM, revealed the staffi (A) with two (2) licensed staff (Registered I) ty based staffing program although one was eping System used for this facility from 01. U were as follows: two (2) CNAs with one in CNAs on 01/26/17, 01/27/17, 01/31/17, 02. CNA (4) with one CNA entering at 3:30 AM on 01/30/17, and, five (5) CNAs and one (1) 2) licensed staff scheduled each night. Inter- of Nursing and other staff came in to help o rough 02/08/17 revealed there was no docur lity admitted Resident #2 on 03/04/16 with ment, dated 11/03/16, revealed the facility i (BIMS) score of fifteen (15) which indicate vealed the resident was a two (2) person as /06/17 at 1:00 PM, revealed he/she was who bed to chair and back. The resident stated at is/her call light, it sometimes takes a long t n to get out of bed. He/she stated he/she sho lity admitted Resident #6 on 10/21/15 with which was performed in 7/2016. Review of c cognition as intact with a BIMS score of fi caled the resident was continent of bowel at /07/16 at 3:30 PM, revealed he/she had to p ident #6 stated it happens mostly happens c minutes to over an hour for the call light to f call lights were answered in a timely mant tell her he/she needs to go to the restroom. 1 en it happens which is at least five (5) time lity admitted Resident #7 on 08/15/15 with M. Resident #7 stated, I can't get anyone to he anxiety causes him/her to have chest pair o (2) days ago and he/she had tool all over revealed this has happened before.	20NFIDENTIALITY**         Keeping System, it was determined the facility acticable physical, mental and 42, #6, and #7).         to get up in the morning when he/she y which caused him/her to feel humiliated, aused Resident #7's [MEDICAL CONDITION] bag to 'her to feel humiliated and dirty. Refer to         ng matrix she wanted for night shift was four Surse {RN} or Licensed Practical Nurse {LPN}. available.         26/17 to 02/08/17 revealed CNA staffing for the orientation on 01/28/17, 01/29/17, 02/01/17, 02/01/17, 02/01/17, 02/01/17, three (3) CNAs with one (1) on orientation or 00/208/17; two CNAs with one (1) on orientation coming in at 4:00 AM on 02/04/17. Further review of the nented evidence the DON worked any shifts at night.         [DIAGNOSES REDACTED]. Review of the Quarterly issessed Resident #2's cognition as intact with a d the resident was interviewable. Further is for transfers.         elchair bound with bilateral amputations and had around 5:00 AM to 6:00 AM, he/she wants to me for someone to answer and can take till ould be able to get out of the bed when he/she         [DIAGNOSES REDACTED]. Resident #6 also has a the Quarterly MDS assessment, dated 01/23/17, revealed fteen (15) which indicated the resident was do cocasionally incontinent of bladder.         ee on myself multiple times due to staff not n night shift between the hours of 2:00 AM and be answered. The resident further revealed is in a week.         [DIAGNOSES REDACTED]. Review of the Quarterly cognition as intact with a BIMS score of 15         in a week.         [DIAGNOSES REDACTED]. Review of the Quarterly is a settleft of the revealed it hakes shim/her feel sin a week.         [DIAGNOSES R		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED:7/6/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185340	(X2) MULTIPLE CONSTRUC A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 02/08/2017
NAME OF PROVIDER OF SU	PPLIER		STREET ADDRESS, CITY, STA	ATE, ZIP
SIGNATURE HEALTHCAR	E OF GLASGOW REHAB & WI	ELLNESS C	220 WESTWOOD ST. GLASGOW, KY 42141	
	home's plan to correct this deficien	• •		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICI MATION)	ENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0490	(continued from page 5) a timely manner and residents ma	where to wait over an hour to ge	at help	
Level of harm - Actual harm	Interview with Licensed Practical get the care they should. She furth	Nurse (LPN) #1, on 02/08/17 at her stated its happened a lot lately	5:00 AM revealed when there is le	
Residents Affected - Few	appropriate staffing to meet all th		on 02/08/17 at 5:50 PW, revealed t	ney expected to have
EORM CMS 2567(02.00)	Event ID: VI 1011	Easility ID: 19		