

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

PRINTED: 11/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185249</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>JACKSON MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>96 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A standard health survey was conducted on 10/16-18/12. Deficient practice was identified with the highest scope and severity at 'E' level.  An abbreviated standard survey (KY19179) was also conducted at this time. The complaint was substantiated with deficient practice identified.	F 000	The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	1) The incident related to resident 6 was reported to us as a complaint of neglect. The incident was investigated by the Administrator per facility policy and a 5 day report was filed as required. Our conclusion was that the cause of the fall was related to the resident leaning and was not the result of staff action 2) The DON is to review all reports of incidents, injuries of unknown origin, grievances, and the facility 24 hour reports for the past 3 months to ensure that all incident and injuries of unknown origin were indeed investigated per facility policy. Social Services is to interview all interviewable residents to inquire about any incidents that may have occurred to ensure a report of the incident was made and that the incident was investigated per facility policy. Administrator/DON reviewed		

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

*P. H. Allison*

TITLE

*Adm*

(X6) DATE

*11-28-12*

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 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy it was determined the facility failed to ensure an incident of suspected neglect was immediately reported to the state survey and certification agency and failed to have evidence that the incident had been thoroughly investigated for one of eleven sampled residents (Resident #6). On 10/03/12, the facility's Administrator and Director of Nursing were made aware Resident #6 sustained a fall from an unlocked wheelchair while sitting unsupervised in the facility dining room. Interview revealed the facility did not consider the staff's failure to ensure safety measures were followed to prevent Resident #6 from sustaining a fall as an allegation of neglect and did not conduct an investigation or notify the state agencies of the report. (Refer to F 323.)</p> <p>The findings include:</p> <p>A review of the facility's Abuse Prohibition Policy and Procedure (not dated) revealed the policy defined neglect as a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The policy</p>	F 225	<p>all abuse allegations for past 6 months to ensure timely reporting of each to the state agencies, including the state survey and certification agency. This will be completed by 11/29/12.</p> <p>3) The DON will present an in-service to staff on 11/30/12 regarding the facility abuse policy and the investigation that occurs with any incident. This in-service will be repeated monthly for 3 months then annually. All newly hired employees will be educated by the DON during orientation. Corporate Consultant will review Abuse Policy with the DON and Administrator on 11-29-12 to ensure understanding of the facility policy on reporting all allegations of abuse immediately to the state agencies including the state survey and certification agency. Upon receiving a report of suspected abuse or neglect, the facility DON or Administrator will notify the VP of Operations or the facility corporate consultant to ensure compliance with the facility abuse policy. A copy of the initial report and 5 day report will be sent to the VP of Operations for review to ensure compliance with the facility policy.</p>	

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F 225	<p>Continued From page 2</p> <p>further stated all incidents and reports of resident abuse/neglect would be reported to all agencies as required.</p> <p>A review of the medical record for Resident #6 revealed the resident was admitted to the facility on 05/18/12 with diagnoses of Alzheimer's Dementia, Bipolar Disorder, Depression, Muscle Weakness, and Osteoporosis. Review of the Care Area Assessments (CAA) completed with the admission assessment, dated 05/24/12, revealed Resident #6 was at risk for falls due to impaired mobility related to muscle weakness. The CAA revealed Resident #6's risk for falls was increased due to the resident's cognitive status which impacted transitions, coordination, balance, walking, and safety awareness. Review of monthly physician's orders revealed Resident #6 had routinely received the medications, Aspirin and Plavix, which can increase bleeding/bruising tendencies.</p> <p>Review of the Comprehensive Care Plan that addressed falls, dated 05/24/12, revealed measures to prevent falls for Resident #6 included a bed/chair alarm, low bed, and to position the resident in the center of bed with use of a wedge.</p> <p>A review of Resident #6's most recent Quarterly Minimum Data Set (MDS) assessment dated 08/24/12, revealed facility staff assessed Resident #6 to be cognitively impaired and to require extensive assistance from two staff members for any activity of daily living.</p> <p>Review of the Incident Report dated 10/03/12 at 11:15 AM, revealed Resident #6 sustained a fall</p>	F 225	<p>4)</p> <p>The DON is to review all reports of incidents and injuries of unknown origin to ensure the investigation is completed appropriately and the root cause of all incidents is identified. The corporate consultant will review all incidents monthly for 3 months and provide additional training as necessary on the facility policy. Regarding investigations. The DON and Corporate Consultant are to report findings to the facility QA committee. Corporate Consultant to review all reports of suspected abuse, neglect or injuries of unknown origin monthly to ensure the facility abuse policy is followed including the reporting requirements. Results of these reviews will be presented to the facility QA committee no less than quarterly to ensure ongoing compliance with the abuse policy including notifications, protection of residents, investigations and reporting.</p>	12/01/12

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F 225	<p>Continued From page 3</p> <p>from a wheelchair. The Incident Report concluded the fall was consistent with the resident leaning forward in the wheelchair but the report failed to identify causative factors for Resident #6's fall. The report revealed Resident #6 was found on the floor lying on his/her left side near a dining room table. However, the Incident Report failed to indicate if Resident #6 had been supervised in the dining room, if the resident's wheelchair had been locked/secured, or if the chair alarm was in place and activated.</p> <p>Review of the nurse's notes and facility transfer form revealed Resident #6 was evaluated following the fall on 10/03/12 at a clinic next door to the facility and staff was instructed to arrange for Resident #6 to be evaluated at the Emergency Room. According to the nurse's notes dated 10/03/12 at 9:00 PM, Resident #6 returned to the facility with a diagnosis of minor head injury with a hematoma to the left frontal region without fracture or intracranial hemorrhage.</p> <p>Observation during the initial tour on 10/19/12 at 9:20 AM, revealed Resident #6 lying on a pressure relieving curved edge mattress with the bed positioned low to the floor. A bed/tab alarm was attached to the resident's clothing. Resident #6's face was severely bruised. Resident #6 did not respond verbally to questions asked.</p> <p>Observation during a skin assessment conducted by LPN #1 on 10/15/12 at 3:30 PM, revealed a large hematoma above the resident's left eye. Bruising was noted of the resident's knees bilaterally, inner thigh, and chest area. Resident #6 was wearing an incontinence brief and was dependent on staff for turning and positioning</p>	F 225			

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F 225	<p>Continued From page 4 during the skin assessment.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 10/16/12 at 4:40 PM, revealed she assessed Resident #6 after a fall on 10/03/12. LPN #3 stated Resident #6 had been transferred from the bed to a wheelchair by CNA #4 and CNA #12, and was transported to the dining room by CNA #12. LPN #3 revealed staff assigned to the dining room for lunch was to be there at 11:15 AM, to prepare drinks for residents and assist with applying clothing protectors to residents. LPN #3 stated CNA #9 was assigned to the dining room on 10/03/12 but was not in the dining room when Resident #6 was taken to the dining room at approximately 11:15 AM. LPN #3 acknowledged CNA #12 should not have left Resident #6 unattended/unsupervised in the dining room. LPN #3 stated upon assessing for contributing factors to the fall she determined Resident #6's wheelchair had not been locked, the chair alarm had not been attached to Resident #6, and the resident had been left unattended/unsupervised in the dining room. LPN #3 stated she completed Verbal/Coaching Forms for CNAs #9 and #12 because the CNAs did not perform their job duties as assigned.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 10/17/12 at 12:15 PM, revealed she went to the dining room when notified of Resident #6's fall on 10/03/12. LPN #2 acknowledged she moved the wheelchair back from the resident to assist with an assessment of the resident. LPN #2 confirmed the wheelchair was not locked and revealed the chair alarm had not sounded.</p> <p>Interview on 10/17/12 at 1:30 PM, with CNA #3</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>revealed she observed Resident #6 on the dining room floor on 10/03/12. CNA #3 confirmed the wheelchair was not locked and the chair alarm did not sound and stated both were in good working order. CNA #3 stated the cord from the chair alarm was hanging on the back of the wheelchair. CNA #3 stated when the cord is clipped to the resident's clothing and the resident leans forward, the alarm cord will detach from the alarm box and will activate the alarm; however, CNA #3 stated Resident #6's alarm was still connected to the alarm box at the time of the fall. CNA #3 stated when a resident was taken to the dining room in a wheelchair the person that transported the resident was responsible to ensure the wheelchair locks were engaged and should stay in the dining room until the CNA assigned to the dining room was present.</p> <p>An interview attempted with CNA #12 by telephone on 10/17/12 at 2:25 PM, was unsuccessful; however, CNA #12 returned the call and an interview was conducted at 9:26 PM on 10/17/12. CNA #12 stated she applied the chair alarm after transferring Resident #6 from the bed to the wheelchair and had locked Resident #6's wheelchair when she positioned the resident at a table in the dining room. CNA #12 stated she routinely checked to ensure residents' wheelchairs were locked. CNA #12 stated several residents had completed an activity when she entered the dining room and approximately 20 residents were in the dining room awaiting lunch. CNA #12 stated CNA #9 was assigned to the dining room and even though CNA #9 or other staff was not present in the dining room when she arrived to the dining room with Resident #6, she left the resident</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>unsupervised in the dining room. CNA #12 acknowledged she should not have left Resident #6 in the dining area unsupervised.</p> <p>Review of the Verbal/Coaching Form dated 10/03/12, for CNA #9 revealed the CNA was assigned to the dining room for lunch but was not in the dining room as assigned when Resident #6 sustained a fall.</p> <p>Review of the Verbal/Coaching Form for CNA #12 revealed Resident #6's chair alarm was not properly attached and did not sound when Resident #6 fell from the wheelchair; however, documentation revealed CNA #12 reported the alarm had been attached to Resident #6's lower back. The form further revealed Resident #6's wheelchair was not locked but CNA #12 reported she had locked the wheelchair. According to the Verbal/Coaching Form, performance improvement was expected from the CNAs and both CNAs had been instructed to provide resident care according to the care plan. The forms revealed CNAs #9 and #12 were suspended for three days. Further review revealed the Verbal/Coaching Forms had been signed by the Director of Nursing (DON).</p> <p>Interview with the DON on 10/17/12 at 4:30 PM, confirmed she had been notified of Resident #6's fall on 10/03/12 by LPN #3 and had received Verbal/Coaching Forms regarding CNAs #9 and #12. The DON confirmed she had interviewed CNA #12 and the CNA stated she had attached the chair alarm and locked the wheelchair. The DON confirmed CNAs #9 and #12 were suspended for three days due to repeated poor job performance reports, frequent absenteeism,</p>	F 225			

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F 225	Continued From page 7 and termination had been considered before Resident #6's fall. The DON confirmed CNA #9 did not follow her assignment by not being in the dining room as required and CNA #12 apparently did not lock the wheelchair as required. The DON confirmed CNA #12 should not have left Resident #6 in the dining room unsupervised/unattended. The DON acknowledged she had not considered the fall incident as a result of neglect and had not thoroughly investigated to determine causative factors. The DON stated the Administrator was responsible to report abuse allegations to state agencies.  Interview with the Administrator on 10/18/12 at 2:45 PM, revealed the Administrator had not considered Resident #6's fall to be an allegation of abuse or neglect, and therefore had not thoroughly investigated the incident or reported the allegation to state agencies when the incident occurred on 10/03/12. The Administrator acknowledged when Adult Protective Services entered the facility on 10/15/12 to investigate an allegation of neglect/abuse related to Resident #6's fall, he notified state agencies and began an investigation.	F 225		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	F 253	1) The tile in both bathrooms was cleaned on 10/17/12 by the DOM and housekeepers. The missing grout was replaced by the DOM on 11/02/12. The area where the small piece of tile was missing was repaired and the small cracks in the tile were grouted by	

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F 253	<p>Continued From page 8</p> <p>determined the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable interior. The women's shower room had broken/cracked tile on the wall of the shower stall with sharp edges and the drain on the floor of the shower room had sharp edges. In addition, the men's and women's shower rooms had a black "mold-like" substance on the tile grout of the floor and walls of the shower stalls.</p> <p>The findings include:</p> <p>Interview with the Administrator on 10/18/12 at 12:55 PM, revealed the facility did not have a policy for housekeeping/maintenance for the shower rooms. The Administrator stated when the housekeeper was hired the Housekeeping Supervisor toured the facility with the newly hired housekeeper and told them what areas they would be responsible to clean.</p> <p>Observations of the shower rooms during the environmental tour on 10/17/12 and 10/18/12 revealed the women's shower room had broken/cracked tiles on the shower stall wall that had sharp edges, and a drain on the floor had sharp edges. In addition, the men's and women's shower rooms had a black "mold-like" substance on the floors and walls in the tile grout.</p> <p>Interview with the Maintenance Supervisor on 10/18/12 at 9:55 AM, revealed the Maintenance Supervisor did not know about the broken/cracked tiles, the drain with sharp edges, or the black "mold-like" substance on the tile grout. The Maintenance Supervisor stated the housekeepers usually took care of the shower</p>	F 253	<p>the DOM on 11/02/12 The drain was raised on 11/02/12.</p> <p>2) The DOM, housekeeping supervisor and administrator made rounds of all common areas and shower areas to insure no other areas were in need of repair on 11/08/12.</p> <p>3) Rounds will be made no less than monthly by the DOM, housekeeping supervisor and administrator to inspect all common areas, shower rooms and resident care areas to ensure all maintenance and housekeeping issues have been identified and addressed. A facility checklist will be used to identify and issues.</p> <p>4) Our regional director of maintenance will tour the facility no less than quarterly to ensure all maintenance and housekeeping issues have been addressed. The facility checklist will be reviewed and any issues will be reported no less than quarterly to the facility QA committee.</p>	11/12/12

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F 253	Continued From page 9 rooms, and CNAs and nurses were to report/document damages on a logbook that was kept at the nurses' station. The Maintenance Supervisor stated he reviewed the log daily to see if there was anything that needed repair, and had not been made aware of the shower rooms.  Interview with the Housekeeping Supervisor on 10/18/12 at 12:40 PM, revealed a weekly inspection was completed on all rooms including the shower rooms. The Housekeeping Supervisor was unaware of the broken cracked tile, the drain with sharp edges, or the black "mold-like" substance on the tile grout. The Housekeeping Supervisor stated the shower rooms should be cleaned once in the morning and once in the evening, and any broken/damaged areas should be reported to the Maintenance Supervisor for needed repairs.  Interview with the Administrator on 10/18/12 at 12:55 PM, revealed the tile grout in the shower rooms was to be cleaned daily in the morning and in the evening. In addition, the Administrator stated staff was to report anything that was in need of repair to the Maintenance Supervisor, and the Administrator was unaware staff had not followed the facility's process.	F 253			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1) The incident related to resident 6 was reported to us as a complaint of neglect. The incident was investigated by the Administrator per facility policy and a 5 day report was filed as required. Our conclusion was that the cause of the fall was related to the resident leaning and was		

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F 323	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure one of eleven sampled residents (Residents #6) received adequate supervision and appropriate use of assistive devices to prevent accidents. Facility staff had assessed Resident #6 to be cognitively impaired, require extensive assistance with activities of daily living, require the use of a bed/chair alarm when up, and at risk for falls due to impaired mobility related to muscle weakness. On 10/03/12 at 11:15 AM, Resident #6 sustained a fall from a wheelchair. The facility failed to ensure staff maintained Resident #6's safety while he/she was in a wheelchair in the dining room and failed to ensure staff monitored the resident's safety while in the dining room. Additionally, the facility failed to identify the causative factors related to Resident #6's fall. (Refer to F 225.)  The findings include:  Review of the facility policy titled Falls Management, (dated 01/01/10) revealed the facility would screen all residents to identify possible risk factors that may place a resident at risk for falls, to evaluate those risks, implement interventions to reduce those risks and monitor those interventions, and modify when necessary. The policy further revealed all resident falls would be investigated to determine appropriate interventions to put in place to reduce the	F 323	not the result of staff action. The resident was evaluated by the therapy department for seating recommendations on 10/04/12. Resident care plans were updated to reflect the therapy recommendations. 2) The DON is to review all reports of incidents, injuries of unknown origin, grievances, and the facility 24 hour reports for the past 3 months to ensure that all incident and injuries of unknown origin were indeed investigated per facility policy. Social Services is to interview all interviewable residents to inquire about any incidents that may have occurred to ensure a report of the incident was made and that the incident was investigated per facility policy. This will be completed by 11/20/12. The DON and ADON are to review all Fall Risk assessments by 11/20/12 to ensure all risk factors have been identified and appropriate care plans are in place. The DON and ADON are to make rounds to ensure all safety measures that are care planned are in place, this will be completed by 11/20/12. 3) The nursing staff is to be re-educated by the DON on 11/30/12 regarding following the resident care plans related to safety measures and on general safety measures that should be in place for all residents, I.E. call bell in reach, wheelchairs locked when		

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F 323	<p>Continued From page 11</p> <p>likelihood that a fall would reoccur and/or minimize the risk of injury related to a fall. According to the DON, the facility did not have a policy addressing wheelchair safety.</p> <p>A review of the medical record for Resident #6 revealed the facility admitted the resident on 05/18/12 with diagnoses of Alzheimer's Dementia, Bipolar Disorder, Depression, Muscle Weakness, and Osteoporosis. Review of the Care Area Assessments (CAA) dated 05/24/12, completed with the admission assessment, revealed Resident #6 was at risk for falls due to impaired mobility related to muscle weakness. The CAA revealed the risk for falls was increased due to the resident's cognitive status which impacted transitions, coordination, balance, and walking and safety awareness. Review of monthly physician's orders revealed Resident #6 had routinely received the medications, Aspirin and Plavix, which can increase bleeding/bruising tendencies.</p> <p>Review of the Comprehensive Care Plan that addressed falls, dated 05/24/12, revealed measures to prevent Resident #6 from falls included a bed/chair alarm, low bed, and for staff to position the resident in the center of the bed with use of a wedge. The care plan failed to address any interventions to prevent falls from the wheelchair.</p> <p>A review of Resident #6's Quarterly Minimum Data Set (MDS) assessment dated 08/24/12, revealed facility staff assessed Resident #6 to be cognitively impaired and to require extensive assistance from two staff members for any activity of daily living.</p>	F 323	<p>stationary, beds locked, etc. This in-service will be repeated monthly for 3 months then no less than annually. All newly hired employees will be educated by the DON during orientation. Staff nurses are to make rounds daily to ensure safety measures are in place per the resident care plan.</p> <p>4) The DON and ADON are to make rounds weekly for 4 weeks then no less than every 2 weeks for 3 months then monthly to ensure all safety measures are in place as identified for each resident based on facility assessment and according to the resident care plan. Problems will be addressed with staff when identified. Results of these rounds will be reported to the facility QA committee no less than quarterly.</p>	11/30/12	

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F 323	Continued From page 12  Review of the Incident Report dated 10/03/12 at 11:15 AM, revealed Resident #6 sustained a fall from a wheelchair. The report revealed Resident #6 was observed on the floor lying on his/her left side. The Incident Report concluded the fall was consistent with the resident leaning forward in the wheelchair.  Review of the nurse's notes and facility transfer form revealed Resident #6 was evaluated following the fall on 10/03/12 at a clinic next door to the facility and staff was instructed to arrange for Resident #6 to be evaluated at the Emergency Room. According to the nurse's notes dated 10/03/12 at 9:00 PM, Resident #6 returned to the facility with a diagnosis of minor head injury with a hematoma to the left frontal region without fracture or intracranial hemorrhage.  Observation during the initial tour on 10/16/12 at 9:20 AM, revealed Resident #6 lying on a pressure relieving curved edge mattress with the bed positioned low to the floor. A bed/tab alarm was attached to the resident's clothing. Resident #6's face was severely contused and bruised, and the resident did not respond verbally to questions asked.  Observation during a skin assessment conducted by LPN #1 on 10/15/12 at 3:30 PM, revealed a large hematoma above the resident's left eye. Bruising was noted of the resident's knees bilaterally, inner thigh, and chest area. Resident #6 was wearing an incontinence brief and was dependent on staff for turning and positioning during the skin assessment.	F 323			

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F 323	<p>Continued From page 13</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 10/16/12 at 4:40 PM, revealed she assessed Resident #6 after a fall on 10/03/12. LPN #3 stated Resident #6 had been transferred from the bed to a wheelchair by CNA #4 and CNA #12, and was transported to the dining room by CNA #12. LPN #3 revealed staff assigned to the dining room for lunch was to be there at 11:15 AM, to prepare drinks for residents and assist with applying clothing protectors to residents. LPN #3 stated CNA #9 was assigned to the dining room on 10/03/12 but was not in the dining room when Resident #6 was taken to the dining room at approximately 11:15 AM. LPN #3 acknowledged CNA #12 should not have left Resident #6 unattended/unsupervised in the dining room. LPN #3 stated upon assessing for contributing factors to the fall she determined Resident #6's wheelchair had not been locked, the chair alarm had not been attached to Resident #6, and the resident had been left unattended/unsupervised in the dining room. LPN #3 stated she completed Verbal/Coaching Forms for CNAs #9 and #12 for failure to follow assignments and ensure resident safety.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 10/17/12 at 12:15 PM, revealed she went to the dining room when notified of Resident #6's fall on 10/03/12. LPN #2 acknowledged she moved the wheelchair away from the resident to assist with an assessment of the resident. LPN #2 confirmed the wheelchair was not locked and revealed the chair alarm had not sounded.</p> <p>Interview on 10/17/12 at 3:45 PM, with CNA #4 revealed she assisted CNA #12 with transferring Resident #6 to a wheelchair on 10/03/12. CNA</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>#4 stated she had applied a pillow for positioning for Resident #6 and was in front of the wheelchair while CNA #12 applied the chair alarm to the back of Resident #6's wheelchair. CNA #6 stated she did not observe CNA #12 attach the chair alarm clip to the resident's clothing but felt she had applied it since she removed the alarm from the bed and placed it on the resident's wheelchair. CNA #4 stated CNA #12 transported Resident #6 to the dining room.</p> <p>Interview on 10/17/12 at 1:30 PM, with CNA #3 revealed she observed Resident #6 on the dining room floor on 10/03/12. CNA #3 confirmed the wheelchair was not locked and the chair alarm did not sound and stated both were in good working order. CNA #3 stated the cord from the chair alarm was hanging on the back of the wheelchair. CNA #3 stated when the cord is clipped to the resident's clothing and the resident leans forward, the alarm cord will detach from the alarm box and will activate the alarm, but Resident #6's alarm was still connected to the alarm box at the time of the fall. CNA #3 stated when a resident was taken to the dining room in a wheelchair the person that transported the resident was responsible to ensure the wheelchair locks were engaged, and should stay in the dining room until the CNA assigned to the dining room arrived.</p> <p>An interview was conducted with CNA #12 on 10/17/12 at 9:26 PM. CNA #12 stated she transferred Resident #6 from the bed to the wheelchair on 10/02/12 and had locked Resident #6's wheelchair when she positioned the resident at a table in the dining room. CNA #12 stated CNA #9 was assigned to the dining room and</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>even though CNA #9 or other staff was not present in the dining room when she arrived to the dining room with Resident #6, she left the resident unsupervised in the dining room. CNA #12 acknowledged she should not have left Resident #6 in the dining area unsupervised.</p> <p>Review of facility in-services revealed an in-service had been conducted on 08/17/12 and directed staff not to leave residents alone in the dining room prior to meal service. According to the facility in-service sign-in sheet, CNAs #12 and #9 had attended the in-service.</p> <p>Review of the Verbal/Coaching Form dated 10/03/12, for CNA #9 revealed the CNA was assigned to the dining room for lunch but was not in the dining room as assigned when Resident #6 sustained a fall.</p> <p>Review of the Verbal/Coaching Form for CNA #12 revealed Resident #6's chair alarm was not properly attached and did not sound when Resident #6 fell from the wheelchair; however, documentation revealed CNA #12 reported the alarm had been attached to Resident #6's lower back. The form further revealed Resident #6's wheelchair was not locked but CNA #12 reported she had locked the wheelchair. According to the Verbal/Coaching Form, performance improvement was expected from the CNAs and both CNAs had been instructed to provide resident care according to the care plan. The forms revealed CNAs #9 and #12 were suspended for three days. Further review revealed the Verbal/Coaching Forms had been signed by the Director of Nursing (DON).</p>	F 323			

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F 323	Continued From page 16 interview with the DON on 10/17/12 at 4:30 PM, confirmed LPN #3 notified her of Resident #8's fall on 10/03/12 and the DON received the Verbal/Coaching Form regarding CNAs #9 and #12. The DON confirmed she interviewed CNA #12 and the CNA informed the DON she had attached the chair alarm and locked the wheelchair. The DON confirmed CNAs #9 and #12 were suspended for three days due to repeated poor job performance reports and frequent absenteeism. The DON acknowledged CNA #12 should not have left Resident #8 in the dining room unsupervised/unattended. The DON confirmed the Incident Report and Post Fall Investigation Tool form did not address causative factors related to Resident #8's fall and she depended on the nursing staff to conduct the falls investigations.	F 323			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the medication error rate was not, and did not exceed, five percent. Staff was observed on 10/17/12 to administer forty-five medications during a medication pass observation. Of the forty-five medications, staff failed to administer Levothyroxine (a thyroid hormone) in accordance with the manufacturer's recommendations on four different occasions during the medication pass.	F 332	The correct medications were given as ordered by the physician to the correct resident, at the time ordered, at the dosage ordered, using the route ordered. TSH levels were monitored and were normal. 1) The administration times for the Levothyroxine have been changed as noted below. These actions were completed on 10/18/12 by the charge nurse. Resident C time changed to 6 a.m. with no contraindicated medications. Resident 11 time changed to 6 a.m. with no contraindicated medications. Resident 6 time changed to 6 a.m. with no contraindicated medications.		

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F 332	<p>Continued From page 17</p> <p>As a result of the four errors, the facility's medication error rate was 8.8 percent.</p> <p>The findings include:</p> <p>According to the Director of Nursing (DON), the facility did not have a policy related to medication administration but provided literature from an in-service conducted on 06/10/12 related to medication administration. The in-service directed staff to follow the five rights (right patient, right drug, right dose, right time, and right route) when administering medications to residents.</p> <p>Review of the manufacturer's recommendations and the facility's PDR 2012 Edition Nurse's Drug Handbook for administration of Levothyroxine revealed the medication should be taken on an empty stomach preferably before breakfast. Further review revealed Levothyroxine should not be administered within four hours of taking calcium supplements or iron supplements as these products interfere with the absorption of Synthroid.</p> <p>1. Observation of a medication pass on 10/17/12 revealed staff failed to follow manufacturer's guidelines when administering Levothyroxine (a thyroid hormone). Observation revealed Kentucky Medication Aide (KMA) #1 administered 100 micrograms (mcg) of Synthroid to unsampled Resident C in combination with seven other medications, including Poly Iron (iron supplement) at 9:05 AM. Resident C received the iron supplement with the Synthroid which was not in accordance with the manufacturer's recommendation. Additionally, Resident C received the medications after the breakfast meal</p>	F 332	<p>Resident D time changed to 6 A.M. with no contraindicated medications.</p> <p>2) The DON reviewed the physicians orders and Medication Administration Records for all residents on 11/08/12 to ensure that any medication recommended to be administered on an empty stomach were scheduled before breakfast.</p> <p>3) The pharmacy will review all records monthly to make sure for appropriate timing (before or after meals, on an empty stomach and etc.) and for administration of medication in combination with other medication that may interfere with effectiveness. Any problems will be communicated with the DON and will be referred to the MD for changes. The consultant pharmacist is to provide education to nurses and KMA's on medications recommended to be given on an empty stomach, with meals and medication that may interfere with the effectiveness of other medication when given together on 11/27/12 to ensure that any medication recommended to be administered on an empty stomach were scheduled before breakfast.</p> <p>4) The administrator is to review consultant pharmacist reviews monthly for 3 months</p>		

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F 332	<p>Continued From page 18</p> <p>had been served and as a result, KMA #1 failed to ensure the Synthroid was administered to the resident on an empty stomach as recommended.</p> <p>2. At 9:15 AM on 10/17/12, KMA #1 administered five oral medications to Resident #11. KMA #1 was observed to administer 88 mcg of Synthroid in combination with Os-Cal (a calcium supplement). KMA #1 failed to ensure Resident #11 did not receive the Synthroid within four hours of taking a calcium supplement as recommended by the medication's manufacturer. Resident #11 received the medications after the breakfast meal had been served and, as a result, KMA #1 failed to ensure the Synthroid was administered to the resident on an empty stomach as recommended by the manufacturer.</p> <p>3. Continued observation revealed KMA #1 administered 25 mcg of Synthroid in combination with six additional medications to Resident #6 at 9:50 AM on 10/17/12. However, the medications, including the Synthroid, were administered after the breakfast meal had been served.</p> <p>4. At 10:08 AM on 10/17/12, KMA #1 prepared Synthroid 50 mcg along with eight oral medications and administered the medications to unsampled Resident D. The Synthroid was administered after the breakfast meal had been served.</p> <p>Interview with kitchen staff on 10/16/12 at 9:15 AM, revealed the scheduled time for the breakfast meal to begin was 7:30 AM.</p> <p>KMA #1 confirmed in interview conducted on 10/17/12 at 10:40 AM, that she administered the</p>	F 332	<p>then no less than quarterly to ensure recommendations are being addressed. Don to review MAR's monthly for 3 months then no less than quarterly to ensure that manufacturer recommendations are being followed in regards to medication administration. Results of these reviews will be reported no less than quarterly to the facility QA committee.</p>	11/30/12

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F 332	Continued From page 19 Synthroid following the breakfast meal and in combination with other medication. KMA #1 stated she was not aware of any specific recommendations for administering Synthroid and administered the medications at the times specified on the Medication Administration Record (MAR).  Interview on 10/17/12 at 10:50 AM, with the DON revealed Synthroid should be administered before breakfast and the MAR should have the medication scheduled for administration at 6:00 AM. The DON stated iron supplements should not be given with Synthroid. The DON stated she was not aware Synthroid was scheduled on the MAR for 10:00 AM.	F 332		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	1) The bag of soiled laundry was removed from the floor when noted by staff and sent to the laundry. The soiled brief and wipes were removed from the floor as soon as noted and disposed of properly by staff. 2) DON made rounds on 10/18/12 and 10/19/12 to observe for any other infection control issues, she observed shower areas, resident rooms, and dining rooms for evidence of hand washing, for handling of soiled linens, of disposal of soiled briefs and wipes and for appropriate glove usage. 3) Nursing staff is to be re-educated on infection control policies related to handling	

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F 441	Continued From page 20 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility in-services, it was determined the facility failed to maintain an effective Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for one of eleven sampled residents (Resident #3). Observation on 10/16/12 during a skin assessment revealed Kentucky Medication Aide (KMA) #3 failed to properly dispose of a soiled incontinence brief and soiled moistened wipes. KMA #3 provided incontinence care for Resident #3 and placed the soiled incontinence brief and soiled moistened wipes on the floor beside the resident's bed. Additionally, observation on 10/17/12 at 4:00 PM, of the shower room revealed staff had placed a plastic bag of soiled/wet linen on the shower room floor.	F 441	of soiled linens, disposal of soiled briefs, hand washing and glove use by the DON on 11/30/12. This in-service will be repeated monthly for 3 months then no less than annually.. All newly hired nursing staff will be educated during orientation by the DON. 4) The DON will make rounds twice a week, on both day and evening shifts, for 4 weeks then weekly at random times to observe for deficient practice. This will continue for 3 months. Findings will be reported to the facility QA committee for evaluation and determination of frequency of rounds after three months.	11/06/12

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NAME OF PROVIDER OR SUPPLIER  JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 98 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 21</p> <p>The findings include:</p> <p>Review of the facility's policy titled Standard Precautions, dated 08/01/12, revealed soiled clothing, personal care items, and soiled/dirty linens should not be placed on the floor. Review of an in-service provided to staff, dated 06/15/12, revealed staff was instructed to never place soiled briefs on a resident's chair or bed, or on the floor.</p> <p>Observation during a skin assessment for Resident #3 on 10/16/12 at 12:25 PM, revealed KMA #3 assisted Licensed Practical Nurse (LPN) #1 with turning the resident. During the skin assessment, Resident #3 became incontinent of bowel. KMA #3 provided incontinence care for Resident #3 and used disposable moistened wipes. KMA #3 was observed to place the soiled incontinence brief and soiled disposable moistened wipes directly on the floor next to Resident #3's bed.</p> <p>Interview conducted on 10/18/12 at 11:25 AM, with KMA #3 revealed she was knowledgeable of the requirement to place soiled items in a trash bag and not to place items on the floor. KMA #3 stated she had helped LPN #1 with turning of Resident #3 for a skin assessment but was not prepared for incontinence care. KMA #3 acknowledged she should have obtained a trash bag for the soiled brief, and confirmed that by placing the soiled brief and wipes on the floor germs could be transmitted throughout the facility on staff's shoes and would be an infection control issue.</p>	F 441			

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F 441	Continued From page 22 In addition, observation of the women's shower room on 10/17/12 at 4:00 PM, revealed a plastic laundry bag containing wet soiled liners had been placed directly on the shower room floor.  Interview with CNA #5 and LPN #3 on 10/17/12 at 4:05 PM and 4:10 PM, revealed staff was not to place soiled laundry and/or liners on the floor. According to CNA #5 and LPN #3, staff was to place soiled items in barrels located in the shower rooms in an effort to avoid cross-contamination of the shower floor.  Interview with the Director of Nurses (DON) on 10/18/12 at 2:45 PM, revealed staff was trained to never place soiled items on the floor in an effort to prevent cross-contamination. The DON stated she was unaware staff was not following the facility's established policies to prevent transmission of germs.	F 441			
F 500 SS=B	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT  If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section.  Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to	F 500	1) An agreement was received on 10/17/12 for one of the dialysis center and the other dialysis center has stated they they will send their agreement by 11/12/12. 2) The Administrator reviewed agreements with any other outside agencies to ensure agreements were present and up to date on 11/9/12. 3)		

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F 500	Continued From page 23 professionals providing services in such a facility; and the timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure there was a written agreement with an outside dialysis center for two of two sampled residents (Residents #9 and #10) that received dialysis treatments.  The findings include:  Interview with the Administrator on 10/18/12 at 11:00 AM, revealed the facility did not have a contract with a dialysis center to provide dialysis to residents of the facility.  1. Review of the medical record for Resident #10 revealed the facility admitted Resident #10 on 12/20/11 with a diagnosis of End Stage Renal Disease. Documentation revealed Resident #10 received dialysis from Dialysis Center #1 on a weekly basis.  2. Review of the medical record for Resident #9 revealed the facility admitted Resident #9 on 10/11/12 with a diagnosis of End Stage Renal Disease. Documentation revealed Resident #9 received dialysis from Center #2 on a weekly basis.  Interview with the Administrator on 10/18/12 at 11:00 AM, revealed the facility did not have a contract with a dialysis center. The Administrator stated until Residents #9 and #10 were admitted to the facility, the facility had not had any	F 500	The administrator is responsible to ensure that agreements with all outside agencies remain current. 4) The administrator will report on status of agreements with outside agencies no less than quarterly for 3 quarters then annually to the facility QA committee.	11/13/12	

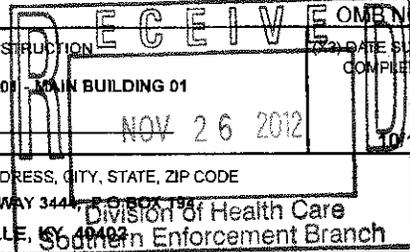
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NAME OF PROVIDER OR SUPPLIER  JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 86 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
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F 500	Continued From page 24 residents for a while that required dialysis. Although the Administrator was aware the facility was required to obtain a contract, the Administrator stated they had forgotten to obtain contracts when the residents were admitted and required dialysis.	F 500			

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NAME OF PROVIDER OR SUPPLIER  JACKSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 344, P.O. BOX 198 ANNVILLE, KY 40402 Division of Health Care Southern Enforcement Branch
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K 000	INITIAL COMMENTS  BUILDING: 01  PLAN APPROVAL: 1989  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type V (III)  SMOKE COMPARTMENTS: 5  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)  EMERGENCY POWER: Type II diesel generator  A life safety code survey was initiated and concluded on 10/16/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.  Deficiencies were cited with the highest deficiency identified at "D" level.	K 000	The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	1) This exit is from an outside court yard and not from the building. The facility has contacted a security company to install a magnetic lock for the gate which will be integrated into the facilities fire alarm system so that it will	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Pha Kulling</i>	TITLE <i>Adm.</i>	(X8) DATE 11-23-12
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  <b>JACKSON MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402</b>	
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K 038	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were readily accessible to the public way. This deficient practice affected one of five smoke compartments, staff, residents, and visitors. The facility has the capacity for 64 beds with a census of 56 on the day of the survey.</p> <p>The findings include:</p> <p>During the life safety code tour on 10/16/12 at 10:45 AM, with the Director of Maintenance (DOM) observation revealed an exit that led to a keyed lock gate in a courtyard. The lock was on the outer part of the gate. A box to the side of the gate contained a key that was accessible by breaking the glass. Exits are required to be reasonably accessible to the public way. This type of locking arrangement is not an obvious method of operation according to code requirements. Emergency lighting is also required to the public way.</p> <p>An interview with the DOM on 10/16/12 at 10:45 AM, revealed he thought this locking arrangement was suitable. The DOM stated there was no emergency lighting to the public way from this exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K 038	<p>release when the fire alarm system is activated wither manually or automatically. A keypad is installed next to the gate with the code posted so that egress is possible at any time. A light will be installed on the corner of the building so that the entire area to the public way is life. This work is scheduled to be completed on 12/01/12.</p> <p>2) All emergency exits were checked on 11/08/12 to assure that they were properly locked and lighted to the public way.</p> <p>3) The administrator, DOM and house-keeping supervisor make monthly rounds to inspect the building and inspection of exit doors to assure that doors are properly locked and the route to the public way lighted and not blocked will be added to these rounds.</p> <p>4) The regional director of maintenance will inspect emergency exits at least quarterly to assure compliance. He will also check our documentation each quarter to make sure that monthly inspections have been done.</p>	12/01/12

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K 038	Continued From page 2 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.  7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.  7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:  For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.	K 038			
K 062 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	1) A sprinkler company has been contracted to replace any heads with paint on the by the DOM. The company will have the new heads installed by 12/01/12		

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K 062	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinkler heads were maintained. This deficient practice affected one of five smoke compartments, staff, residents, and visitors. The facility has the capacity for 61 beds with a census of 56 on the day of the survey.</p> <p>The findings include:</p> <p>During the life safety code tour on 10/16/12 at 10:30 AM, with the Director of Maintenance (DOM) observation revealed paint on a sprinkler head at the front entrance canopy. Foreign matter on sprinkler heads decreases their ability to react as intended in a fire situation.</p> <p>An interview with the DOM on 10/16/12 at 10:30 AM, revealed he had not noticed the paint on the sprinkler head. The DOM stated he would have this sprinkler head and others evaluated by the facility's sprinkler contractor.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Reference: NFPA 13 (1999 Edition).</p>	K 062	<p>2) All smoke compartments have been checked by the DOM on 11/08/12 and no paint, corrosion or foreign material were present. There was no apparent damage and the orientation was correct.</p> <p>3) The administrator, DOM and house-keeping supervisor do rounds of the building monthly and checking sprinkler heads for damage, corrosion, foreign material, paint and proper orientation will be added to the check list.</p> <p>4) The regional director of maintenance will inspect sprinkler heads in one smoke compartment per quarter until all compartments have been inspected. He will also check our documentation each quarter to make sure that monthly inspections have been done.</p>	12/01/12

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K 062	Continued From page 4 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.	K 062			