

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

PRINTED: 09/28/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/15/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON MATHERS NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2323 CONCRETE ROAD CARLISLE, KY 40311</b>
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F 000	INITIAL COMMENTS		Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update</p>	F 157	<p>F 157 Resident #7's physician was made aware of episodes of crying and behaviors and an order was received from physician for new PRN medication to help control anxiety. Family was notified of resident behavior and the new medication order.</p> <p>All residents have the potential to be affected. Nursing Admin Team including the DON, ADON, QI Nurse, MDS Nurses and SDC Nurse reviewed progress notes for the last 30 days on 10/6/2011 for all other residents to identify other residents where</p>	10/10/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin	(X6) DATE 10/7/11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1 the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to notify the physician of changes in clinical conditions for one (1) of fifteen (15) sampled residents, Resident #7. Resident #7 was having recurrent episodes of anxiety and tearfulness; however, there was no documented evidence the physician was notified.</p> <p>The findings include:</p> <p>Review of the clinical record revealed the facility admitted Resident #7 on 04/14/11 with diagnoses of Alzheimer's Dementia and Depression. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/01/11 revealed Resident #7 could not participate in a cognitive assessment; however, staff assessed the resident as being severely impaired. In the same MDS, the staff assessment of the resident's mood revealed no symptoms.</p> <p>Review of the Nurses Notes dated 07/27/11 revealed "Resident has periods of crying at times". Review of the Nurses Notes dated 07/29/11 revealed "Resident often speaks of not having money and has to do something". Review of the Nurses Notes dated 09/13/11 revealed "Resident has had episode of crying and complaining about not having enough money". There was no documented evidence in the Nurses Notes of Resident #7's attending</p>	F 157	<p>notification of changes may be warranted. None were identified.</p> <p>All licensed nurses were re-educated on 10/6/2011 &amp; 10/7/2011 by the DON regarding the right of all residents to have their physician and family member/legal representative informed when there is an accident involving the resident; there is a change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly or a decision to discharge or transfer the resident.</p> <p>Progress notes will continue to be reviewed by the Nursing Admin Team daily, Monday through Friday, for appropriate notification of physicians and family members/legal representatives. The results of these reviews will be reported at the weekly QI meeting for four (4) weeks then monthly thereafter. The QI Nurse will also review the Behavior Observation Profile documentation for each resident and report those results at the weekly QI Committee meeting.</p> <p>The results of these weekly meetings will be reported monthly to the Quality Improvement Executive Committee</p>	

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F 157	<p>Continued From page 2</p> <p>physician being notified of these episodes of worrying about money and tearfulness.</p> <p>Observation, on 09/13/11 at 9:45 AM, revealed Resident #7 quietly sitting in the common area of the locked unit for memory impaired residents. The resident was observed to walk to his/her room, sit down, and start to cry. Further observation revealed Resident #7 cried and talked repeatedly about not having enough money and expressed concerns about what he/she was going to do. The resident cried for a half an hour though there were several attempts to reassure and redirect the resident during this time period by staff.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 09/13/11 at 9:55 AM, revealed this resident's recurrent episodes of tearfulness had been addressed last April in a psychiatric consultation but Resident #7 had continued to have these tearful, anxious episodes on a regular basis, several times a week.</p> <p>Interview with the Social Worker, on 9/14/11 at 11:45 AM, revealed the family only allowed the one (1) psychiatric consult in April 2011. Interview further revealed the family did not want him/her involved with a psychiatrist and a lot of psychiatric medications. The Social Worker continued to say staff redirected him/her when he/she was anxious.</p> <p>Interview, on 09/15/11 at 7:00 PM, with LPN #4 revealed she usually worked with Resident #7 and the resident often had spells of crying about money; she was not sure how long the spells lasted in the mornings or how many times per</p>	F 157	<p>consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p>		

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F 157	<p>Continued From page 3</p> <p>week Resident #7 had these behaviors. The LPN stated, staff didn't always document the episodes of crying and had never called the physician about the behaviors.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 09/15/11 at 2:30 PM, revealed staff was to try to reassure the resident when he/she got anxious and worried, as about money. The ADON further stated this was normal behavior for him/her. Continued interview, revealed the physician did not prescribe anti-anxiety medications for Resident #7. The ADON said she would try to find in the Nurse's Notes where they had notified the physician of Resident #7's crying and anxiety spells about money. The ADON later stated she was not able to find such documentation.</p> <p>Interview, on 09/15/11 at 3:50 PM, with Resident #7's attending physician revealed, "I saw the resident in July 2011 and he/she did not exhibit any anxiety. I was not aware it was an ongoing concern". The physician stated he had only treated the resident since July 2011; however, stated he would be at the facility within the next twenty-four (24) hours to assess the situation.</p> <p>Interview with the resident's son/Power of Attorney (POA), on 09/15/11 at 4:00 PM, revealed he was not aware the resident was having these anxious, tearful episodes on a regular basis. The resident's son stated, he would want the resident to be treated for his/her distress at these times if it was possible and would have no objections to a physician's intervention and possible medications for his/her symptoms.</p>	F 157		

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F 157	Continued From page 4 Interview with the resident's spouse, on 09/15/11 at 6:55 PM, revealed he/she did not know about these episodes of crying and anxiety in the mornings and was surprised to hear about them. The resident's spouse stated, he/she would not be opposed to the resident being treated for anxiety. He/she stated, "I'm not opposed to him/her having medication to help him/her. I don't want him/her to suffer."	F 157		
F 159 SS=E	<p><b>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</b></p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p>	F 159	<p>F159 Resident Request for Personal Funds Protocol was developed by Administration on 10/4/2011.</p> <p>All residents for whom the Nursing Home manages their personal funds may be affected.</p> <p>All residents and their responsible parties for whom JMNH manages their personal funds were provided information regarding the protocol established for accessing their personal funds by mail on 10/5/2011. All staff was educated by the SDC Nurse on 10/6/2011 &amp; 10/7/2011 regarding the protocol established for accessing residents' personal funds.</p> <p>Resident satisfactions surveys have been updated to include resident satisfaction with regards to access of personal funds. The results of these satisfaction surveys will be reported monthly to the Quality</p>	10/10/11

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F 159	<p>Continued From page 5</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure resident's personal funds were available for unlimited access through petty cash on an ongoing basis.</p> <p>The findings include:</p> <p>Interview with the Business Office Manager, on 09/15/11 at 4:15 PM, revealed after 4:30 PM each day residents did not have access to their personal funds, and would not have access until 7:00 AM the next day. Further interview revealed on Saturdays and Sundays funds were only available from 10:00 AM until 2:00 PM when the weekend manager was on duty.</p> <p>Interview with the Administrator, on 09/15/11 at</p>	F 159	Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.	

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F 159	Continued From page 6 4:30 PM, revealed she was aware residents did not have unlimited access to the funds. Further interview revealed residents would be able to get funds but someone would have to notify Administration to come to the facility to access the funds.	F 159		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy it was determined the facility failed to implement written policies and procedures related to screening all potential employees for a history of abuse, neglect or mistreatment of residents. Two (2) of five (5) employee files reviewed, revealed an abuse registry check was not completed prior to the hire date.  The findings include:  Review of the facility's policy titled "Abuse, Neglect, or Misappropriation of Resident Property Policy", dated 02/09, revealed potential employees will be screened by the facility for abuse, neglect or misappropriation of property. Further review revealed the screening process will include the requesting of information from licensing boards and/or registries.	F 226	F226 The policy, "Abuse, Neglect, or Misappropriation of Resident Property" and the supporting protocol "Hiring New Employees" were reviewed by the Administrator on 10/4/2011 and determined to require no revision to meet the intent of this regulation. The SDC Nurse and the Payroll Clerk were re-educated by the Administrator on 10/5/2011 regarding the background check of all new employees to include a check for listing on the nurse aide abuse registry prior to employee reporting to work.  A 100% audit of all personnel records was completed by the Administrator on 9/28/2011 to determine if all current employees had a check of the nurse aide abuse registry in their file. One employee was identified and the record check with the nurse aide abuse registry was re-obtained on 9/28/2011 and no concerns were identified on the abuse registry.	10/10/11

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F 226	<p>Continued From page 7</p> <p>Review of employee files revealed two (2) non-nursing personnel started work at the facility prior to having nurse aide abuse registry checks.</p> <p>Interview with the Staff Development (SD) Nurse, on 09/15/11 at 2:00 PM, revealed she was unaware of the requirement to complete abuse registry checks on non-nursing personnel.</p> <p>Interview with the Administrator, on 09/15/11 at 3:00 PM, revealed Administration was not aware the abuse registry checks had not been completed before the hiring of all new employees. Further interview revealed the previous SD Nurse failed to ensure the new SD Nurse was aware of the requirement to request the abuse registry on all new employees.</p>	F 226	<p>All managers were re-educated by the Administrator on 9/28/2011 at the Department Managers meeting that background checks for all employees included a check of the nurse aide abuse registry.</p> <p>The SDC Nurse will review the personnel file of new employees prior to orientation to determine that all background checks have been completed by the Payroll Clerk and the results deem the person eligible for hire. The results of these reviews will be reported weekly to the QI Committee for four weeks then monthly thereafter.</p>	
F 241 SS-D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to promote care for residents in a manner that enhanced each resident's dignity for one (1) of fifteen (15) sampled residents (Resident #10). Resident #10 was observed to be brought into the dining room for lunch inadequately groomed with his/her hair disheveled.</p>	F 241	<p>The results of these weekly meetings will be reported monthly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p> <p>F241 Resident # 10 was returned to his/her room by the Certified Nursing Assistant and provided ADL care including</p>	10/10/11

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F 241	<p>Continued From page 8 The findings include:</p> <p>Review of the facility grooming policy revealed "grooming will be performed daily and as needed (PRN)". Further review of "Resident's Rights", a document provided to the resident or their responsible party upon admittance to the facility, revealed "Residents have the right to be suitably dressed at all times and given assistance when needed in maintaining body hygiene and good grooming".</p> <p>Observation, on 09/13/11 at 12:05 PM, in the South Dining Room revealed Resident #10 was wheeled into the dining room late and ungroomed. The resident was still in his/her gown and robe and his/her hair was sticking out in every direction and flat in the back.</p> <p>Review of Resident #10's clinical record, revealed the facility admitted the resident with diagnoses which included Alzheimer's Disease, Dementia, and Depression.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 05/27/11, revealed the facility assessed the resident as having severe impairment in cognitive skills for daily decision making. Further review revealed the facility assessed the resident as requiring extensive assistance of one (1) with dressing and hygiene.</p> <p>Review of Resident #10's Comprehensive Plan of Care, dated 08/04/11, revealed the resident had the potential for unmet needs and compromised dignity due to cognitive deficit related to his/her diagnosis of Dementia. The Plan of Care stated the resident was to be provided physical</p>	F 241	<p>grooming and hair being combed on 9/13/11.</p> <p>All residents have the potential to be affected. Admin Nurse Team consisting of DON, ADON, QI Nurse, SDC Nurse and MDS Nurse, made rounds throughout the building to visually survey all residents for appropriate grooming on 9/14 and 9/15/2011. No other concerns were identified.</p> <p>All staff were re-educated by the SDC Nurse, DON and/or Administrator with regard to dignity for all residents and that the facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. In-service re-education was provided beginning 9/26/2011 and completed on 10/7/2011.</p> <p>Admin Nurse Team, including the DON, ADON, QI Nurse, MDS Nurses and SDC will continue to monitor resident care being provided in a manner that respects each resident's dignity as a part of their daily rounds, Monday through Friday. The results of these rounds will be documented on the Daily Rounds QI tool. Any concerns identified</p>	

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F 241	<p>Continued From page 9</p> <p>assistance such as combing hair, brushing teeth, etc., for the daily maintaining of appearance.</p> <p>Interview with CNA #9, on 09/13/11 at 12:05 PM, revealed she did not know why the resident was ungroomed at lunch; she saw the resident at the nurse's station and brought him/her to the dining room to feed him/her.</p> <p>Interview, on 09/13/11 at 12:15 PM, with Licensed Practical Nurse (LPN) #3, who was assigned to Resident #10, revealed the resident should have been groomed and his/her hair combed before being brought to the dining room for lunch. The LPN explained, Certified Nurse Assistant (CNA) #10, who was assigned to the resident, had been pulled to another hall at 9:00 AM. She further stated, CNA #8 was then sent to take CNA #10's place on the South Hall where it appeared that none of the residents had been showered or bathed prior to 9:00 AM. LPN #3 stated, maybe there was a miscommunication between the two aides but Resident #10 should have been groomed before being taken to lunch.</p> <p>Interview with CNA #8, on 09/15/11 at 2:45 PM, who was assigned to Resident #10 on the morning of 09/13/11, revealed, apparently CNA #10 did not change everyone when she got them up. She stated the residents were wearing Attends, not pull-ups, and were "in a mess", which further slowed her down. CNA #8 further stated, she did not groom Resident #10 before lunch because they were "short-staffed" that morning. Further interview with CNA #8 revealed two (2) aides had "called in" and she was the only aide on the hall except for the Kentucky Medication Assistant (KMA) who was</p>	F 241	<p>during these rounds will be addressed &amp; corrected as indicated. The QI Rounds tools and the results of these rounds will be reported at the weekly QI meeting for four (4) weeks then monthly thereafter.</p> <p>The results of these weekly meetings will be reported monthly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/15/2011
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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F 241	<p>Continued From page 10 administering medications.</p> <p>Further interview with CNA #8, on 09/15/11 at 2:55 PM, revealed going to the dining room for lunch ungroomed, not appropriately dressed with hair disheveled compromised Resident #10's dignity and individuality. She stated, "I wouldn't do it", which when clarified meant she would not go to the dining room to eat lunch looking like that.</p> <p>Interview by phone with CNA #10, on 09/13/11 at 3:00 PM, revealed she was assigned to Resident #10 prior to being switched to a different unit and had put shoes, socks and housecoats on residents, put their dentures in and combed their hair so they could go to breakfast that morning at around 7:15 AM. She stated, Resident #10 had breakfast in his/her room that morning. CNA #10 said she was moved to the North Hall between 8:30 AM and 9:30 AM. She further stated, "I didn't comb Resident #10's hair because I was going to bathe him/her later but got pulled off the hall.</p> <p>Interview with the Director of Nursing (DON), on 09/13/11 at 3:15 PM, revealed the staff should have combed Resident #10's hair and groomed the resident properly prior to taking him/her to the dining room for lunch. The DON had no explanation for why this was not done for Resident #10.</p>	F 241		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal</p>	F 312	<p>F312 Resident # 10 was returned to his/her room by the Certified Nursing Assistance on 9/13/2011 and provided ADL care including grooming and hair being combed.</p>	10/10/11

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NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON MATHERS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2323 CONCRETE ROAD CARLISLE, KY 40311</b>		
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F 312	<p>Continued From page 11 and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to provide the necessary grooming services for one (1) of fifteen (15) sampled residents, (Resident #10). The facility failed to carry out activities of daily related to grooming for Resident #10 who was unable to independently groom self and was brought to the dining room for lunch ungroomed.</p> <p>The findings include:</p> <p>Review of the facility grooming policy revealed "grooming will be performed daily and as needed (PRN)." Further review of "Resident's Rights", a document given to each resident or their responsible party at admittance to the facility, revealed "Residents have the right to be suitably dressed at all times and given assistance when needed in maintaining body hygiene and good grooming.</p> <p>Observation, on 09/13/11 at 12:05 PM, in the South Dining Room revealed Resident #10 was wheeled into the dining room by staff for lunch ungroomed. Observation revealed Resident #10 was still in his/her gown and robe and his/her hair was sticking out in every direction and flat in the back as if uncombed.</p> <p>Review Resident #10's medical record, revealed the facility admitted the resident with diagnoses</p>	F 312	<p>All residents unable to carry out activities of daily living have the potential to be affected. Admin Nurse Team consisting of DON, ADON, QI Nurse, SDC Nurse and MDS Nurse, made rounds throughout the building to visually survey all residents for appropriate grooming on 9/14 and 9/15/2011. No other concerns were identified.</p> <p>All nursing staff was re-educated by the SDC Nurse, DON and/or ADON with regard to providing appropriate care and services to all residents who are unable to perform their own ADL care independently. In-service education was provided beginning 9/15/2011 and completed on 10/7/2011.</p> <p>Admin Nurse Team, including the DON, ADON, QI Nurse, MDS Nurse, and SDC Nurse will monitor for resident care being provided in a manner appropriate for each resident as identified on the Resident Care Guide through their daily rounds, Monday through Friday. The results of these rounds will be documented on the Daily Rounds QI tool. Any concerns identified during these rounds will be addressed &amp; corrected as indicated.</p>		

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F 312	<p>Continued From page 12</p> <p>which included Alzheimer's Disease, Dementia and Depression. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/27/11; revealed Resident #10 was unable to participate in a cognitive assessment; however, staff assessed the resident as being severely impaired in cognitive skills for daily decision-making. Further review, revealed the facility had assessed Resident #10 as requiring extensive assistance in performance of Activities of Daily Living (ADL's) involving personal hygiene and grooming and required the support of one person for those tasks.</p> <p>Review of Resident #10's Comprehensive Plan of Care, dated 08/04/11, revealed Resident #10 was provided a Care Plan for personal hygiene with the following description: "provide physical assist such as comb hair, brush teeth, etc. for the daily maintaining of appearance related to cognitive impairment". The resident was also provided a Care Plan requiring staff to meet "unmet needs and compromised dignity due to cognitive deficit due to his/her diagnosis of dementia".</p> <p>Interview with CNA #9, on 09/13/11 at 12:05 PM, revealed she saw the resident at the nurse's station and brought him/her to the dining room to feed him/her. She was unaware of why the resident was not groomed prior to being brought to the nurse's station.</p> <p>Interview, on 09/13/11 at 12:15 PM, with Licensed Practical Nurse (LPN) #3 revealed Resident #10 should have been groomed prior to being brought into the dining room for lunch. The LPN explained, the aide assigned to Resident #10, Certified Nurse Assistant (CNA) #10, had been</p>	F 312	<p>The QI Rounds tools and the results of these rounds will be reported at the weekly QI meeting for four (4) weeks then monthly thereafter.</p> <p>The results of these weekly meetings will be reported monthly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p>	

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F 312	<p>Continued From page 13</p> <p>pulled to another hall that morning at 9:00 AM. CNA #8 was then switched to South Hall. LPN #3 stated, there may have been a miscommunication between the two aides.</p> <p>Interview with CNA #8, on 09/15/11 at 2:45 PM, who had been assigned to Resident #10 on the morning of 09/13/11, revealed she was switched to South Hall at 9:00 AM; and it appeared that none of the residents there had been showered or bathed prior to 9:00 AM. She stated apparently CNA #10 did not change everyone when she got them up. CNA #8 further stated she did not get Resident #10 groomed before lunch because they were "short-staffed" and she was busy giving showers. CNA #8 stated two (2) staff had "called in" that morning and she was the only aide on the hall except for the Kentucky Medication Assistant (KMA) who was busy administering medication.</p> <p>Interview by phone with CNA #10, who no longer was employed by the facility, on 09/13/11 at 3:00 PM, revealed she was assigned to Resident #10 prior to being switched to the other unit on 09/13/11 and had put shoes, socks and housecoats on residents and combed their hair before they went to the dining room for breakfast. She stated Resident #10 did not go to the dining room for breakfast that morning; and ate breakfast in his/her room. The CNA further stated, she didn't comb his/her hair because she was going to bathe him/her later.</p> <p>Interview with the Director of Nursing (DON), on 09/13/11 at 3:15 PM, revealed staff should have combed Resident #10's hair and groomed her/him properly before taking the resident to the</p>	F 312		

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F 312	Continued From page 14	F 312		
F 314	dining room for lunch.			
SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	Resident #9 was immediately assessed by the Treatment Nurse, the physician and resident representative were contacted; treatment and interventions were initiated on 9/14/2011.	10/10/11
	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure residents having pressure sores receive necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for one (1) of fifteen (15) sampled residents, (Resident #9). Resident #9 was observed on 09/14/11 to have an unidentified Stage II pressure sore to the coccyx.</p> <p>The findings include:</p> <p>Review of the facility policy "Pressure Ulcer Prevention", dated 01/10, revealed residents who had been assessed as moderate/high risk for pressure ulcer development would be placed on a preventive program. "Inspect skin and notify appropriate personnel of abnormal changes. Note: remember that skin inspections are done in different ways. They are done many times a day</p>		<p>All residents have the potential to be affected. A 100% skin audit was conducted by the DON, ADON, &amp; Treatment Nurse on 9/27/2011 to identify any other residents who may have skin issues not already identified. One resident was identified to have a skin issue not already receiving treatment per the Treatment Nurse.</p> <p>Licensed Nurses were re-educated on 10/6/2011 &amp; 10/7/2011 by the DON on the facility protocol for ensuring skin assessments were conducted on a routine basis. Certified Nursing Assistants were re-educated on 10/6/2011 by 10/7/2011 by the DON &amp; ADON on the facility's protocol for identifying &amp; reporting any skin issues to the Licensed Nurses for further assessment &amp; treatment as indicated.</p>	

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F 314	<p>Continued From page 15 during daily care by Certified Nursing Assistants (CNA's) and Licensed Personnel. Abnormalities, if any, are then noted. Skin inspections are also done by Treatment Nurse during treatments".</p> <p>Review of Resident #9's clinical record revealed diagnoses which included a Fracture of the Right Femur 07/05/11. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 08/01/11 revealed the facility assessed the resident as having no impairment in cognitive skills, and as requiring extensive assistance with transfers and bed mobility. Further review revealed the facility assessed the resident as having a Hip Fracture.</p> <p>Review of the Care Area Assessment Summary (CAAS) dated 08/01/11, revealed Resident #9 fell and suffered a Fracture of the Right Femur on 07/05/11 and after surgery for an Open Reduction Internal Fixation (ORIF) returned to the facility for rehabilitation including Physical Therapy and Occupational Therapy. Further review revealed the resident was at moderate risk for skin breakdown related to requiring assistance with Activities of Daily Living (ADL's) including bed mobility, and was to be turned and repositioned frequently. Pressure relieving devices were to be provided for the chair and bed, and skin assessments were to be done per protocol.</p> <p>Review of the Comprehensive Plan of Care, revised on 09/06/11, revealed the resident was at risk for skin breakdown related to requiring assistance with bed mobility, Status Post S/P Fractured Hip. The goal stated the resident would not develop a pressure ulcer. The interventions included; staff were to report to the</p>	F 314	<p>A weekly QI skin audit will be conducted by the Treatment Nurse to identify that any skin issues have been identified &amp; are being treated as ordered. The results of these audits will be reported at the weekly QI meeting for four (4) weeks then monthly thereafter.</p> <p>The results of these weekly meetings will be reported monthly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p>	
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F 314	<p>Continued From page 16</p> <p>nurse any redness or open areas, encourage the resident to change positions in and out of bed, encourage boosting in the wheelchair, skin assessments as indicted, and turn and reposition frequently.</p> <p>Observation of a skin assessment, on 09/14/11 at 10:30 AM; performed by Licensed Practical Nurse (LPN) #5/Wound Nurse, revealed the resident had an open area to the coccyx which the LPN described as a Stage II Pressure sore which measured 1.4 centimeter's (CM) x 1.2 cm's. Interview at the time of the skin assessment with LPN #5 revealed the area was unidentified and she would notify the physician for a treatment.</p> <p>Review of the Progress Notes and Skin Assessments revealed there was no indication the facility was aware of the Stage II Pressure Sore to the resident's coccyx. Further review revealed the last Skin Assessment performed by a licensed nurse was completed 08/17/11.</p> <p>Review of the Physician's Orders dated 09/14/11 revealed orders to cleanse the coccyx with Normal Saline, apply Tegaderm dressing, change as needed, and check dally for placement.</p> <p>Further interview, on 09/14/11 at 10:30 AM and 09/15/11 at 10:00 AM, with LPN #5/Wound Nurse revealed the CNA's were to check the residents' skin during baths and were to let the nurses know if there was a concern. She further stated the nurses were to call her if there was a new area of skin breakdown. Continued interview revealed the residents did not receive weekly skin assessments by a licensed nurse unless the resident had a wound, and she would perform a</p>	F 314		
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F 314	<p>Continued From page 17</p> <p>head to toe skin assessment on residents who were being treated for a wound. Further interview revealed she had provided an inservice on 07/28/11 for the licensed staff and CNA's related to skin assessments, reporting changes to the treatment nurse, pressure ulcer prevention and treatment.</p> <p>Interview, on 09/15/11 at 1:40 PM, with CNA #11, who was assigned to the resident on 09/14/11 revealed the resident received assistance with turning and repositioning and could turn self at times. She further stated she stood the resident up three (3) to four (4) times a shift to relieve pressure. Continued interview revealed the residents received a bed bath or shower every day and the CNA's were to check the skin each day during the bath for any areas of redness or skin breakdown and alert the nurse if problems were found. She stated the resident had an area to the coccyx which was "a little red", but not open on 09/14/11 and the resident complained of soreness to the area. She further stated she reported this to LPN #7 as soon as she found the area.</p> <p>Interview, on 09/14/11 at 3:15 PM, with LPN #7 who was assigned to the resident revealed the resident was receiving Physical Therapy and Occupational Therapy and was propelling self in a wheelchair. She further stated the resident was up in a wheelchair most of the day shift and would sometimes lie down after lunch. Continued interview revealed the resident could shift his/her own weight while in the wheelchair and could turn self in the bed. She stated the nurses did not do weekly skin assessments and the CNA's were to let the nurses know if there was any skin</p>	F 314		
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F 314	Continued From page 18 breakdown. Continued interview revealed she was unaware of any skin breakdown until LPN #5 notified her today after the skin assessment.  Interview, on 09/15/11 at 9:30 AM, with Nuree Consultant #1 revealed the nurses performed skin assessments weekly for the first four weeks for a new admission. She stated the nurses also performed skin assessments quarterly, and with a significant change, and the wound nurse would perform skin assessments on residents who had an actual wound. Continued interview revealed the nurses did not perform weekly skin assessments on the residents who did not have a wound; however, the CNA's were taught to perform skin inspections and were to notify the nurses if there was an area of skin breakdown noted during daily care and baths. Continued interview revealed the CNA's did not do skin assessments because that was not in their scope of practice, but were to let the nurses know if there was any new skin problems found.	F 314		
F 441 SS=D	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	F 441	F441 Re-education was initiated on 9/12/2011 and continued through 10/7/2011 by the SDC Nurse, DON and QI Nurse with the direct care staff on providing a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection including proper storage of the ice scoop in the drawer to the side of the ice chest, proper cleaning of resident's hands prior to trays being passed, proper covering food while it is being transported through the hallway, appropriate hand washing techniques,	10/10/11

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441	<p>Continued From page 19</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to 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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.</p> <p>The findings include:</p>	F 441	<p>cleaning &amp; storage of used resident care equipment, and appropriate bagging of soiled linens.</p> <p>All residents have the potential to be affected. Rounds were conducted by the Admin Nurse Team including the DON, ADON, QI Nurse, MDS Nurse, and SDC Nurse on 9/14/2011 &amp; 9/15/2011 to identify any other infection control concerns. Identified concerns were corrected as appropriate.</p> <p>All facility staff were re-educated again on 10/6/2011 &amp; 10/7/2011 by the DON, SDC Nurse and QI Nurse on maintaining an Infection Control Program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection that included proper storage of the ice scoops in the drawer to the side of the ice chests, proper cleaning of resident's hands prior to trays being passed, proper covering food while it is being transported through the hallway, appropriate hand washing techniques, cleaning &amp; storage of used resident care equipment, and appropriate bagging of soiled linens.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2011  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/15/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON MATHERS NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2323 CONCRETE ROAD CARLISLE, KY 40311</b>
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F 441	<p>Continued From page 20</p> <p>Review of the facility "The Infection Control Program Policy", dated 08/05, revealed the objectives of the program were to ensure compliance with relevant federal, state, and local laws pertaining to infection control.</p> <p>Review of the facility policy, entitled "Handwashing Procedure", dated 08/05, revealed hands should be washed in this manner; turn water on and wet hands, using friction, rub hands together, cleaning under nails and between fingers for ten (10) to fifteen (15) seconds, rinse hands well, when rinsed turn water faucet off with a clean paper towel, discard paper towels in trash container.</p> <p>Observation, on 09/12/11 at 5:05 PM, revealed the ice scoop was lying on top of the ice inside the ice chest of the snack cart.</p> <p>Interview with (Licensed Practical Nurse) LPN #8, on 09/12/11 at 5:15 PM, revealed "the ice scoop is to be placed in the drawer to the side." Further interview revealed, it was against policy to leave the ice scoop lying on top of the ice.</p> <p>Observation, on 09/12/11 at 5:15 PM, revealed staff offered wipes to residents to wash their hands after trays had been passed.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 09/12/11 at 5:15 PM, revealed the residents should have been offered a wipe prior to trays being passed.</p> <p>Observation, on 09/12/11 at 5:35 PM, revealed LPN #2 carrying food through the hallway uncovered to be re-heated and then returning it to</p>	F 441	<p>Rounds will be conducted daily, Monday – Friday, by the Admin Nurse Team including the DON, ADON, QI Nurse, MDS Nurse, and SDC Nurse to observe that appropriate infection control practices are being followed and any issues identified will be corrected immediately and documented on the QI daily rounds sheet. The results of these rounds sheets will be reviewed weekly at the weekly QI meeting for four (4) weeks then monthly thereafter.</p> <p>The results of these weekly meetings will be reported monthly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p>	
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F 441	<p>Continued From page 21 the resident during the evening meal.</p> <p>Interview with LPN #2, on 09/13/11 at 5:50 PM, revealed the plate of food should have been covered when taken out of the resident's room and brought down the hallway. Further interview revealed LPN #2 stated, "Policy tells us not to carry food anywhere uncovered."</p> <p>Observation, on 09/13/11 at 11:37 AM, revealed staff members inappropriately washing their hands. LPN #3 was observed to wash her hands and turn off the water with wet hands. Certified Nursing Assistant (CNA) #4 was observed to place soap in his/her hands, turn on the water, and turn off the water with wet hands.</p> <p>Interview with CNA #4 on 09/13/11 at 11:40 AM, revealed staff had been educated on handwashing procedures. Further interview, revealed the CNA did not indicate as to why she did not follow the policy, but acknowledged she did it incorrectly.</p> <p>Interview with LPN #3 on 09/13/11 at 11:50 AM revealed, she was in a hurry and failed to follow policy.</p> <p>Observation on 09/14/11 at 12:00 PM, revealed a dirty IV (intravenous) pump and pole was stored in the South Wing medication room.</p> <p>Interview with the Director of Nursing (DON) on 09/14/11 at 12:45 PM revealed, "This IV pump does not look clean." Further interview revealed, the IV pump should have been placed in the dirty room in a red bag and sent back to the pharmacy, and the IV pole should have been</p>	F 441		

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F 441	<p>Continued From page 22 cleaned and placed in the clean utility room.</p> <p>Observation, on 09/14/11 at 10:15 AM, revealed CNA #5 picking up dirty linens off the floor with his/her bare hands and placing the linens in a bag.</p> <p>Interview with CNA#5, on 09/14/11 at 12:00 PM, revealed she was in a hurry and failed to don gloves prior to picking up linens from the floor. Further interview revealed she was trying to get everything done quickly. "I know I'm suppose to wear gloves but I was in a hurry."</p> <p>Interview with the Infection Control Nurse, on 09/14/11 at 11:30 AM, revealed it was not proper procedure to place linens on the floor. She stated, linens should be placed in a bag as they are used. She further stated, hand washing was the first line of defense against infections.</p>	F 441		
F 465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>The findings include:</p>	F 465	<p>F465 Repairs to the South wing exit door frames were completed to remove the rust as cited, evacuation sign on the Rising Sun hallway has been replaced, the drain on the water fountain on the south wing has been cleaned, and the wire shelf, the rolling clothes hanger and the gurney on the south unit have been removed from the hallway. All torn window screens were removed from the windows on 9/15/2011 for repair.</p> <p>The refrigerator in the secured unit has been locked with signage in place to keep locked. (Attachment 19) The water hose was removed from the courtyard on 9/14/2011. The oxygen tank holders were removed from the hallway on 9/14/2011. The door to the supply room was closed and locked. Tables in the employee dining room were cleaned of debris, the slats in the window blind were not broken, just bent, now straightened, and the toaster</p>	10/10/11

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F 465	<p>Continued From page 23</p> <p>Observations during the initial tour of the facility on 09/12/11 at 1:10 PM revealed, the following concerns were noted on the South wing; the bottom of the South wing exit doors were found to be rusted, evacuation signs were pulling apart on the Rising Sun hallway, the water fountain on the South wing was noted to have brown colored substance at the drain, a wire shelf was stored behind the shred box at the nursing station, and next to the shred box was a rolling clothes hanger which contained articles of clothing. A gurney was parked next to the exit door on the South Unit. Room 129 had a large hole in the window screen as well as other rooms had torn screens. In the secured unit, the dining area had an unsecured refrigerator (lock was in place, however, not secured). The courtyard had a water hose lying out in the open area exposing residents, staff, and the public to an unsafe walkway.</p> <p>Further observations during the initial tour revealed two (2) oxygen tank holders were noted to be stored outside the smoking area. There was a torn screen observed in the church area. At the timeclock area, next to the mirror, the evacuation sign was torn.</p> <p>Interview, on 09/15/11 at 1:30 PM, with the Administrator, Housekeeping Supervisor and Maintenance Director, revealed the hallway areas were not to be utilized as a storage area for supplies and the torn screens were being repaired on 09/15/11. Further interview revealed the Housekeeping staff needed to clean the brown areas from the water fountain. Additional interview revealed the water hose in the courtyard was a safety risk for all residents, staff and visitors and would be removed immediately. The</p>	F 465	<p>and microwave have been cleaned thoroughly.</p> <p>The central supply door was closed &amp; locked on 9/12/2011. Signage has been placed on the door to remain closed &amp; locked.</p> <p>The bathroom in the therapy area has been converted to storage area only. The files on the stretch table had been placed there temporarily while no residents were in the therapy room for treatment and were filed away immediately on 9/12/2011. The coffee pot was removed from service on 9/12/2011 and the boxes moved from under the sink to appropriate storage area.</p> <p>All residents have the potential to be affected by the environment. Environment Rounds were conducted by the Safety Committee on 9/20/2011; any concerns noted were corrected at the time.</p> <p>Staff were re-educated by the Administrator, DON and SDC Nurse with regard to proper storage and maintaining a clear egress in hallways to provide a safe, functional, sanitary and comfortable environment for our resident, beginning 9/26/2011 through 10/7/2011.</p>	

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F 465	<p>Continued From page 24</p> <p>Administrator stated, the refrigerator should remain locked when not in use and staff would be re-inserviced to the safety risks of an unlocked refrigerator.</p> <p>Observation, on 09/12/11 at 2:30 PM, revealed the central supply door was found open with keys in the door knob allowing anyone access to this supply room including residents. Inside the central supply door was tube feeding materials and supplies, dressing supplies, briefs, etc.</p> <p>Interview, on 09/12/11 at 2:30 PM, with Licensed Practical Nurse (LPN) #7, revealed the door to the supply should remain locked at all times. Further interview revealed LPN #7 did not know who the keys belonged to and she removed the keys and locked the door:</p> <p>Further observations during the initial tour, revealed the staff dining area presented with four (4) tables found with debris on them, two (2) of the window screens had torn areas noted, two (2) of the window blinds had broken slats, rust areas were noted under the soda machine, the microwave had dried food inside, and the toaster had dried food on top. Also, noted under the first window was a hole in the wall.</p> <p>On the Meadowbrook Hall, observation, on 09/12/11 at 2:45 PM, revealed trash behind the handrails and the dietary exit door was noted to have rust.</p> <p>Interview, on 09/12/11 at 4:30 PM, with the Maintenance Director, revealed he had created a monitoring tool with areas that needed repaired but had not been able to correct all issues prior to</p>	F 465	<p>To monitor the facility's compliance of maintaining a safe, functional, sanitary, and comfortable environment, the Safety Committee members will conduct monthly safety inspections. The results of these inspections will be reported monthly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p>	
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NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON MATHERS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2923 CONCRETE ROAD CARLISLE, KY 40311</b>	
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F 465	<p>Continued From page 25 survey. The facility could not provide documented evidence of the scheduled timing of the monitoring tool.</p> <p>Interview, on 09/15/11 at 9:30 AM, with the Administrator revealed the housekeeping department was responsible for cleaning the dining room area but could not explain why food and debris remained on the floor.</p> <p>In the therapy area, observation of the bathroom revealed eight (8) walkers, two (2) quad canes, one (1) flat screen television, one (1) file cabinet, and paper products. The stretch table had three (3) stacks of resident files lined up. Above the stretch table was a radio with a wire hanger utilized as the antenna, boxes were stored on the floor under the sink and a coffee pot was noted on the sink counter and in the on position with hot liquid in the pot accessible to anyone entering the therapy room.</p> <p>Interview, on 09/12/11 at 5:00 PM, with the Occupational Therapist revealed the bathroom was not an appropriate place for storage and prevented therapy patients access to the bathroom. Additional interview, revealed therapy staff would contact Maintenance to request another area for storage.</p> <p>Interview with the Administrator, on 09/15/11 at 1:30 PM, revealed the responsibility to oversee the entire facility was her responsibility but others were held accountable to ensure the facility was well maintained. Further interview revealed, she did not know why the items were left stored in the hallways, but the issues would be taken care of. She further indicated, staff was responsible for</p>	F 465		

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F 465	Continued From page 26 cleaning the microwave and toaster after each use and the housekeeping staff was responsible for cleaning the dining room.	F 465		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1962. Renovated in 1994</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM Installed in 1991 and upgraded in 1994.</p> <p>FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) Installed in 1994.</p> <p>EMERGENCY POWER: Type II Diesel Generator Installed in 1979.</p> <p>A life safety code survey was initiated and concluded on 09/13/11. 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.</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p>	000	<p>Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <p>K025 The space in the smoke barrier located in Whispering Hills Hall has been filled fire stop expanding foam material that meets the requirements for 2 hour rate assemblies. (Attachment K-1)</p> <p>This deficiency had the potential to affect thirty-four residents, staff and visitors in two of five smoke compartments.</p>	10/10/11
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin	(X8) DATE 10/7/11
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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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K 025 SS=D	Continued From page 1  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. Smoke barriers must be maintained to ensure they limit the transfer of smoke and fire into corridors and resident rooms. The deficiency had the potential to affect two (2) of five (5) smoke compartments, thirty-four (34) residents, staff, and visitors.  The findings include:  Observation, on 09/13/11 at 9:45 AM, with the Maintenance Supervisor, revealed the smoke barrier located in Whispering Hills Hall did not extend all the way to the underside of the roof line. The observation was confirmed with the Maintenance Supervisor.  Interview, on 09/13/11 at 9:45 AM, with the	K 025	All other smoke barriers were examined by the Life Safety surveyor and Maintenance Supervisor on the date of the survey, 9/13/2011, no other penetrations were found.  Maintenance Supervisor will inspect all smoke barriers after any work is completed above the ceilings to determine that no penetrations have occurred. This will be reported monthly to the Safety Committee.  The Safety Committee will report monthly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.	

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NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON MATHERS NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2323 CONCRETE ROAD CARLISLE, KY 40311</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	<p>Continued From page 2</p> <p>Maintenance Supervisor, revealed he was unaware that the sheetrock did not go all the way up to the underside of the roofline.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions.</p> <p>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions:</p> <p>a. It shall be made on either side of the smoke partitions.</p> <p>8.2.4 Smoke Partitions.</p> <p>8.2.4.1 Where required elsewhere in this Code, smoke partitions</p>	K 025		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>186028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/13/2011</b>
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K 025	Continued From page 3 shall be provided to limit the transfer of smoke. 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Exception:* Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met: (a) The ceiling system forms a continuous membrane. (b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. (c) The space above the ceiling is not used as a plenum.	K 025	K072 Fire Retardant Treatment Policy was developed and implemented effective 9/30/2011. (Attachment K-2)  All resident have the potential to be at risk.	10/10/11
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficient	K 072	Residents and families were informed of the new policy through a letter mailed 9/26/2011. (Attachment K-3) Maintenance and Houskeeping were Inserviced with regard to the Fire Retardant Treatment Policy 9/26/2011 by the Administrator. (Attachment K-4)  To ensure compliance with the policy, the Safety Committee will review the fire retardant logs maintained by Housekeeping and Maintenance monthly.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/13/2011
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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K 072	<p>Continued From page 4</p> <p>practice has the potential to affect all residents, staff, and visitors. The facility has the capacity for one hundred and four (104) beds and the census on the day of the survey was seventy-two (72) residents.</p> <p>The findings include:</p> <p>Observation, on 09/13/11 between 9:30 AM to 11:30 AM, with the Maintenance Supervisor revealed hanging decorations on resident room doors 101, 105, 106, 108, 118, 119, 121, 123, 124, 132, 137, 141.</p> <p>Interview with the Maintenance Supervisor, on 09/13/11 at 11:30 AM, revealed the facility did not have a policy or system in place to ensure the decorations were treated with a flame retardant material.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p>	K 072	<p>The Safety Committee will report monthly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p>	
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