

From: Jackson Manor

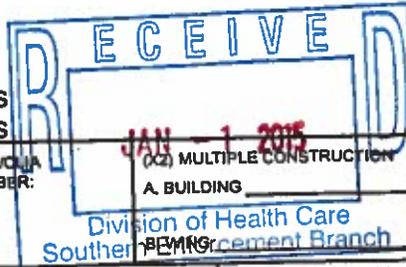
6063642293

01/01/2015 09:00

#192 P.002/024

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

PRINTED: 12/12/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ Division of Health Care Southern Region BEH/RCM Cement Branch	(X3) DATE SURVEY COMPLETED 11/26/2014
NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 96 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 000 F 225 SS=D	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 11/24-26/14. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</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</p>	F 000 F 225	<p>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.</p> <p>1) On 12/15/14 the administrator checked files and all references have been called on all recent new hires. 2) All residents could be affected by this practice. 3) On 12/15/14 the facility changed the check off sheet so that it lists "work history/reference checks verified" separate from "application on file" and all hiring employees and been educated of this as of 12/15/14. 4) The facility administrator will review employee files after one month and then quarterly for one year and then annually thereafter for proper checks/documentation and will report findings to the Quality Assurance Committee.</p>	12/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: P.A. Mulh... TITLE: Adm (X8) DATE: 12-31-14

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.

From: Jackson Manor

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01/01/2015 09:01

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2014
NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER		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 225	<p>Continued From page 1</p> <p>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, personnel record review, and review of facility policy, it was determined the facility failed to ensure past employment work history or reference checks were requested upon hire for two (2) of five (5) personnel records reviewed (Employees #4 and #5).</p> <p>The findings include:</p> <p>Review of the facility's policy, "Abuse Prohibition," not dated, revealed all reference checks will be performed on all employees on information made available by the employee.</p> <p>Review of the personnel record on 11/25/14 at 1:15 PM for Employee #4 revealed the employee's hire date was 10/24/14 and Employee #5 was hired on 10/14/14; however, the facility failed to check the past employment work history or personal reference checks to ensure the employees did not have a history of abuse, neglect, or mistreatment of individuals.</p> <p>Interview with the Dietary Manager on 11/25/14 at 2:01 PM revealed she was responsible for checking the past employment work history and personal reference checks for Employee #4 but failed to do the checks because "I know her."</p> <p>Interview with the Maintenance Manager on 11/25/14 at 2:10 PM revealed he was responsible</p>	F 225		

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 86 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 225	Continued From page 2 for checking the past employment work history and personal reference checks for Employee #5. Further interview revealed he had attempted to contact the previous employer but failed to document the attempt. He also stated Employee #5 had a relative that worked at the facility and he had spoken to this relative about the employee; however, he had also failed to document this reference check. Interview with the Bookkeeping Manager on 11/25/14 at 2:50 PM revealed she was responsible for doing a "final checklist" for new hires; however, it is the responsibility of each Department Head to complete past employment work history and personal reference checks. Further interview revealed the "final checklist" did not include past employment work history or personal references. Interview with the Administrator on 11/26/14 at 11:52 AM revealed all new hires should have reference checks completed.	F 225			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure care was provided in accordance with the resident's written plan of care for one (1) of	F 282	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.		

From: Jackson Manor

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 98 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
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F 282	<p>Continued From page 3</p> <p>thirteen (13) sampled residents (Resident #4). The facility assessed Resident #4 to be at risk for falls. The resident's Comprehensive Care Plan included interventions for the resident to have a low bed with mats at the bedside and for the resident to wear socks and shoes while in the wheelchair. However, observations on 11/24/14 revealed no fall mats in place beside Resident #4's bed nor was the resident wearing shoes while up in the wheelchair.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing on 11/26/14 at 12:43 PM revealed the facility has no written policy concerning Care Plans.</p> <p>Observations made on 11/24/14 at 9:37 AM and 11:50 AM revealed Resident #4 was up in the wheelchair in front of the nurses' station and the resident was not wearing shoes. On 11/25/14 at 9:12 AM Resident #4 was observed up in the wheelchair and was not wearing shoes. Continued observation revealed no mats were present on the floor on either side of Resident #4's bed.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident on 04/09/14, with diagnoses that included Senile Dementia, Type II Diabetes, Alzheimer's disease, Hypertension, Hyperlipidemia, and Cerebrovascular Accident.</p> <p>Review of Resident #4's recent Quarterly Minimum Data Set assessment (MDS) dated 09/27/14, revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status (BIMS) score of 99, which indicated that the facility was not able to interview Resident #4.</p>	F 282	<p>1) On 11/25/14 the staff made sure that shoes, socks and mats were in place and care plan will be adjusted to meet resident needs. 2) Any resident at risk for fall could be affected by this same practice 3) On or before 12/22/14 care plans for all residents deemed to be at risk for falls will be reviewed and these residents will be observed to assure that care plan is being followed. 4) The DON or her designee will review care plans of those who have been determined to be at risk for falls and will observe resident to assure that the care plan is being followed and she will report her findings to the QA committee. This will be done weekly for one month and monthly thereafter.</p>	12/31/14	

From: Jackson Manor

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
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F 282	<p>Continued From page 4</p> <p>The MDS revealed the resident had two falls since admission with no injury. Further review of the MDS revealed the resident required extensive assistance from staff with ambulation.</p> <p>Review of Resident #4's care plan dated 04/16/14, revealed the resident was at risk for falls. The plan of care indicated the resident's impaired cognition, medications, and incontinence placed the resident at increased risk for falls. Fall interventions on Resident #4's plan of care included having mats in place around Resident #4's bed and to wear socks and shoes while up in the wheelchair.</p> <p>Review of Resident #4's Certified Nursing Assistant (CNA) Care Plan, undated, revealed Resident #4 was to have a low bed with mats and was to have socks and shoes on when up in the wheelchair.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 11/26/14 at 11:25 AM revealed she had seen fall mats around Resident #4's bed in the past and they were usually on either side of the resident's bed. SRNA #1 stated that she had worked the hall where Resident #4 lived on 11/25/14, but had not noticed the mats. Continued interview with SRNA #1 revealed she checks the CNA care plan for resident care needs. SRNA #1 stated Resident #4 refuses to wear shoes at times.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2 on 11/26/14 at 11:45 AM revealed she would look at the CNA care plan to see if a resident should have fall mats or should be wearing shoes while in the wheelchair. Further interview with SRNA #1 revealed Resident #4</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>does not like to wear shoes and sometimes refuses to wear them. SRNA #1 stated she was not sure if Resident #4 was to have fall mats next to the bed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 11/26/14 at 12:19 PM revealed she was the charge nurse for A Hall, which is the hall where Resident #4 resides. LPN #1 stated that she is on the hall to do random audits frequently and that she always gives the SRNAs report to update them of any changes to a resident's care plan. Further interview with LPN #1 revealed SRNAs are to check each resident's CNA care plan at the beginning of each shift. Continued interview with LPN #1 revealed she was unaware that Resident #4 did not have fall mats present next to his/her bed on 11/24/14 and 11/25/14. Interview with LPN #1 also revealed Resident #4 had one pair of shoes that he/she liked to wear but they were too small for the resident. Further interview with LPN #1 revealed the facility had acquired another pair of shoes for Resident #4, but the resident refused to wear them. LPN #1 stated the facility had not attempted to try other shoes for the resident and therefore, Resident #4 had not worn shoes for several weeks now.</p> <p>Interview with the Director of Nursing (DON) on 11/26/14 at 12:43 PM revealed she conducts weekly rounds to ensure that resident care plan interventions are being implemented and she attends regular resident care plan meetings. Continued interview with the DON revealed she does a 24-hour report which includes any new orders for residents and then verifies that the resident's care plan has been updated accordingly. According to the DON, she was unaware that Resident #4's care plan</p>	F 282			

From: Jackson Manor

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 98 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
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F 282	Continued From page 6 interventions (wearing shoes while in the wheelchair and having fall mats on the floor by the resident's bed) were not being implemented as directed on the resident's care plan.	F 282			
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. The facility failed to ensure interventions were implemented to prevent falls for one (1) of thirteen (13) sampled residents (Resident #4) as required by the resident's plan of care. The findings include: Observations made on 11/24/14 at 9:37 AM and 11:50 AM revealed Resident #4 was up in the wheelchair in front of the nurses' station and the resident was not wearing shoes. On 11/25/14 at 9:12 AM Resident #4 was observed up in the wheelchair and was not wearing shoes. Continued observation revealed no mats were present on the floor on either side of Resident #4's bed.	F 323	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. 1) On 11/25/14 the staff made sure that shoes, socks and mats were in place and care plan will be adjusted to meet resident needs. 2) Any resident at risk for fall could be affected by this same practice 3) On or before 12/22/14 care plans for all residents deemed to be at risk for falls will be reviewed and these residents will be observed to assure that care plan is being followed. 4) The DON or her designee will review care plans of those who have been determined to be at risk for falls and will observe resident to assure that the care plan is being followed and she will report her findings to the QA committee. This		

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F 323	<p>Continued From page 7</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident on 04/09/14, with diagnoses that included Senile Dementia, Type II Diabetes, Alzheimer's disease, Hypertension, Hyperlipidemia, and Cerebrovascular Accident.</p> <p>Review of Resident #4's recent Quarterly Minimum Data Set assessment (MDS) dated 09/27/14, revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status (BIMS) score of 99, which indicated that the facility was not able to interview Resident #4. The MDS revealed the resident had two falls with no injury since admission. Further review of the MDS revealed the resident required extensive assistance from staff with ambulation.</p> <p>Review of Resident #4's care plan dated 04/16/14, revealed the resident was at risk for falls. The plan of care indicated the resident's impaired cognition, medications, and incontinence placed the resident at increased risk for falls. Fall interventions on Resident #4's plan of care included having mats in place around Resident #4's bed and to wear socks and shoes while up in the wheelchair.</p> <p>Review of Resident #4's Certified Nursing Assistant (CNA) Care Plan, undated, revealed Resident #4 was to have a low bed with mats and was to have socks and shoes on when up in the wheelchair.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 11/26/14 at 11:25 AM revealed she had seen fall mats around Resident #4's bed in the past and they were usually on either side of the resident's bed. SRNA #1 stated that she had</p>	F 323	will be done weekly for one month and monthly thereafter.	12/31/14	

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01/01/2015 09:05

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F 323	<p>Continued From page 8</p> <p>worked the hall where Resident #4 lived on 11/25/14, but had not noticed the mats. Continued interview with SRNA #1 revealed she checks the CNA care plan for resident care needs. SRNA #1 stated Resident #4 refuses to wear shoes at times.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2 on 11/26/14 at 11:45 AM revealed she would look at the CNA care plan to see if a resident should have fall mats or should be wearing shoes while in the wheelchair. Further interview with SRNA #1 revealed Resident #4 does not like to wear shoes and sometimes refuses to wear them. SRNA #1 stated she was not sure if Resident #4 was to have fall mats next to the bed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 11/26/14 at 12:19 PM revealed she was the charge nurse for A Hall, which is the hall where Resident #4 resides. LPN #1 stated that she is on the hall to do random audits frequently and that she always gives the SRNAs report to update them of any changes to a resident's care plan. Further interview with LPN #1 revealed SRNAs are to check each resident's CNA care plan at the beginning of each shift. Continued interview with LPN #1 revealed she was unaware that Resident #4 did not have fall mats present next to his/her bed on 11/24/14 and 11/25/14. Interview with LPN #1 also revealed Resident #4 had one pair of shoes that he/she liked to wear but they were too small for the resident. Further interview with LPN #1 revealed the facility had acquired another pair of shoes for Resident #4, but the resident refused to wear them. LPN #1 stated the facility had not attempted to try other shoes for the resident and therefore, Resident #4 had not worn</p>	F 323			

From: Jackson Manor

6063642293

01/01/2015 09:05

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F 323	Continued From page 9 shoes for several weeks now. Interview with the Director of Nursing (DON) on 11/26/14 at 12:43 PM revealed she conducts weekly rounds to ensure that resident care plan interventions are implemented and she attends regular resident care plan meetings. Continued interview with the DON revealed she does a 24-hour report which includes any new orders for residents and then verifies that the resident's care plan has been updated accordingly. According to the DON, she was unaware that Resident #4's care plan interventions (wearing shoes while in the wheelchair and having fall mats on the floor by the resident's bed) were not being implemented as directed on the resident's care plan.	F 323			
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to obtain laboratory services to meet the needs of one (1) of thirteen (13) sampled residents (Resident #1). Resident #1 had a physician's order dated 10/27/14 for a Basic Metabolic Panel (electrolytes) laboratory level to be drawn every week for two (2) weeks. A review of Resident #1's medical record revealed a Basic Metabolic Panel had been completed on 10/28/14; however, there was no evidence a	F 502	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. 1) A basic metabolic panel was drawn on 11/26/14 and the results were determined to be at levels appropriate for this resident as determined by their physician. 2) All lab work orders for November will be		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/26/2014
NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 96 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 502	Continued From page 10 Basic Metabolic Panel had been obtained for the next week as ordered. The findings include: Interview with the Director of Nursing (DON) on 11/26/14, at 11:15 AM, revealed the facility had no policy related to nursing staff ordering of laboratory levels. Observation of Resident #1 on 11/24/14, at 9:18 AM, revealed the resident was resting in bed on the resident's right side with Glucerna 1.2 (tube feeding) infusing via pump at 50 milliliters per hour. Review of the medical record for Resident #1 revealed the facility admitted the resident on 03/18/14, with diagnoses that included Diabetes Mellitus, Senile Dementia, Dysphagia, and Congestive Heart Failure. Review of physician's orders for Resident #1 revealed a physician's order dated 10/27/14 for a Basic Metabolic Panel (electrolyte levels) laboratory test to be drawn every week for two weeks. Review of laboratory reports for Resident #1 revealed a Basic Metabolic Panel laboratory test had been completed on 10/28/14, and there was no documentation in the medical record that a Basic Metabolic Panel laboratory test had been obtained for the following week as ordered. Interview with Licensed Practical Nurse (LPN) #1 on 11/25/14, at 2:55 PM, revealed she was responsible for placing the order in the computer for Resident #1's Basic Metabolic Panel laboratory test which was to be drawn on 10/28/14. The LPN stated she was also required	F 502	checked to make sure that they have been drawn as ordered checks to be completed no later than 12/19/14. 3) Upon admission and monthly the nursing secretary will check physician order against lab orders to make sure that all lab orders are entered into the system. 4) The DON or her designee will check lab recs against physician orders on at least 5 residents weekly for one month and then monthly.	12/31/14	

From: Jackson Manor

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01/01/2015 09:07

#192 P.013/024

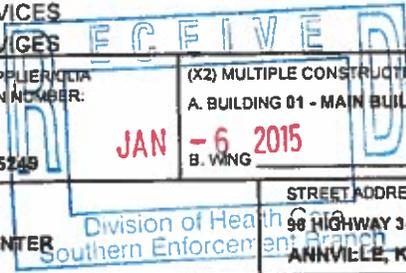
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F 502	Continued From page 11 to fill out a laboratory form for the Nursing Secretary to order the Basic Metabolic panel for the next week. The LPN stated she guessed she had just forgotten to fill out the laboratory form for the Nursing Secretary. Interview conducted with the DON on 11/26/14, at 11:15 AM, revealed nurses were required to place the initial laboratory order into the computer system, and then fill out a written laboratory form. The Nursing Secretary was then responsible to enter any future laboratory tests into the computer. The DON stated the facility had not been monitoring to ensure nurses were accurately completing the handwritten laboratory forms.	F 502			

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 58 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402
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K 000	<p>INITIAL COMMENTS</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1989</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (III)</p> <p>SMOKE COMPARTMENTS: 5</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 11/24/14, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility to not be in compliance with NFPA 101 Life Safety Code, 2000 Edition. The census was 50 residents on the day of the survey. The facility has a capacity for 51 beds.</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p>	K 000		
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 062	<p>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</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>ChA. Huber</i>	TITLE <i>Adm</i>	(X6) DATE 1-6-15
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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 062	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure automatic sprinkler heads were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments. The findings include: Observation on 11/18/14 at 4:18 PM, with the Administrator revealed eight automatic sprinkler heads in the kitchen area were corroded and covered with grease. Further observation revealed three automatic sprinkler heads in the kitchen area were located less than one foot from light fixtures which were below the automatic sprinkler head deflector. Interview with the Administrator revealed the facility relied on an outside contractor to ensure the facility's automatic sprinkler system was maintained properly. Observation on 11/18/14 at 4:22 PM, with the Administrator, revealed two automatic sprinkler heads in the Service Hall area were located less than one foot from light fixtures which were below the automatic sprinkler head deflector. Interview with the Administrator revealed the facility relied on an outside contractor to ensure the facility's automatic sprinkler system was maintained properly. Observation on 11/18/14 at 4:26 PM, with the Administrator revealed two automatic sprinkler heads in the Laundry Area were located less than	K 062	Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law. All sprinkler heads in the kitchen, will be replaced. Those near any obstruction (light fixtures) will be extended to a point where the deflector is below the bottom of the obstruction. The heads in the service hall and the laundry room which are near light fixtures will be extended so that the deflector is below the bottom of the light fixture. The maintenance director will make an inspection throughout the building to make sure that there are no other problem heads and will extend or replace as appropriate. The sprinkler system will be inspected annually or as otherwise required by a qualified technician and our regional director of maintenance will do an additional inspection to assure that the violation will not recur.	1/30/15

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K 062	Continued From page 2 one foot from light fixtures which were below the automatic sprinkler head deflector. Interview with the Administrator revealed the facility relied on an outside contractor to ensure the facility's automatic sprinkler system was maintained properly. Reference: NFPA 25 (1998 Edition). 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. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. Reference: NFPA 13 (1999 Edition). 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of	K 062		

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K 062	Continued From page 3 Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP) Maximum Allowable Distance Distance from Sprinklers to Deflector above Bottom of Side of Obstruction (A) Obstruction (in.) (B) Less than 1 ft 0 1 ft to less than 1 ft 6 in. 2 1/2 1 ft 6 in. to less than 2 ft 3 1/2 2 ft to less than 2 ft 6 in. 5 1/2 2 ft 6 in. to less than 3 ft 7 1/2 3 ft to less than 3 ft 6 in. 9 1/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 16 1/2 5 ft and greater 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).	K 062		