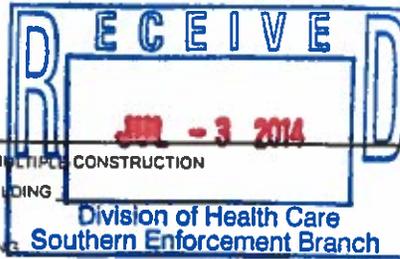


From: Jackson Manor

6063642293

07/03/2014 13:19

#423 P.012/024



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

PRINTED: 06/24/2014  
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  B. WING	(X3) DATE SURVEY COMPLETED  C 06/10/2014
--	--	--	---

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	INITIAL COMMENTS  An abbreviated standard survey (KY21798) was conducted on 06/10/14. The complaint was unsubstantiated with unrelated deficient practice identified at "D" level.	F 000	The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure maintenance and housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior were provided. Observation during the initial tour on 06/10/14 beginning at 9:02 AM revealed there was a brown discoloration around the base of the toilet and a white powdery substance on the top of the sink top in resident room C-12. In addition, there were three uncovered foam wedges observed under Resident A's mattress that were in contact with the floor.  The findings include:  Review of a policy titled, "Housekeeping Orientation List," undated, revealed all bathrooms would be cleaned daily.  Interview conducted with the Housekeeping Supervisor on 06/10/14, at 3:35 PM, revealed the facility did not have a policy or manufacturer's	F 253	There are certain rooms in the building that are scheduled to be cleaned 4 to 6 times per day due to the habits of one or more of the residents in that room. The room in question was one of those rooms. Interview with the housekeeping supervisor indicates that he never saw the discoloration and he further stated that that room had not been cleaned yet that morning at 9:02.  1) The housekeeping supervisor has checked the room each day that he works to make sure that it has been cleaned satisfactorily. 2) There were 6 residents who had previously been determined to have habits which may require	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Phyllis Kublin</i>	TITLE <i>Adm</i>	(X6) DATE 7-3-14
--	---------------------	---------------------

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

6063642293

07/03/2014 13:20

#423 P.013/024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/24/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2014
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 253	<p>Continued From page 1</p> <p>guidelines on how to clean the foam wedges. According to the Housekeeping Supervisor, the facility washed the foam wedges and hung them in the laundry to dry.</p> <p>Observation on 06/10/14, at 9:02 AM revealed a brown discoloration around the base of the toilet and a white powdery substance on the top of the sink in the bathroom of resident room C-12.</p> <p>Observation on 06/10/14, at 9:30 AM revealed three uncovered foam wedges under the mattress of Resident A's low bed that were observed to be in direct contact with the floor.</p> <p>Interview conducted with State Registered Nurse Aide (SRNA) #1 on 06/10/14, at 9:34 AM, revealed the foam wedges on Resident A's bed should have been covered. The SRNA stated she "just forgot."</p> <p>Interview conducted with the Housekeeping Supervisor on 06/10/14, at 3:35 PM, revealed he made rounds several times daily throughout the facility to identify housekeeping concerns. The Housekeeping Supervisor stated staff also notified housekeeping staff if they identified any housekeeping concerns that needed attention. The Housekeeping Supervisor stated he had not been aware of the concerns identified in the bathroom of resident room C-12, and stated the facility washed the foam wedges and hung them in the laundry to dry.</p> <p>Interview conducted with the Director of Nursing (DON) on 06/10/14, at 5:55 PM, revealed the Administrator was unavailable. The DON stated she had not been aware of the concerns identified in the bathroom of resident room C-12,</p>	F 253	<p>extra cleaning and each of their rooms are checked each day by the housekeeping supervisor to make sure that they have been cleaned satisfactorily.</p> <p>3) A check off sheet has been created for each of these rooms and housekeepers are to signoff each time they check the rooms. When housekeepers leave in the evening they are to make sure that there are cleaning supplies to include a bucket, mop and cleaners available for night shift personnel in case extra cleaning is needed at night. All housekeepers have been in-serviced individually on the above mentioned forms and procedures. The director of nursing and the housekeeping supervisor will discuss any new housekeeping concerns at the daily morning meeting and the list of rooms needing extra cleaning will be revised as needed.</p> <p>4) The housekeeping supervisor will continue to check these rooms daily for cleanliness and will check</p>	

From: Jackson Manor

6063642293

07/03/2014 13:20

#423 P.014/024

the check off sheets in the rooms to make sure that they are being utilized. The administrator will check rooms randomly at least once per month to make sure that the rooms are clean and that the check off sheets are being properly utilized and will report findings to the QA committee monthly.

Regarding the foam wedges, note that the wedges were never in contact with any resident, as stated they were under the mattress.

- 1) The wedges were covered and new vinyl covered wedges have been purchased and are in use.
- 2) A check of all other residents in the facility on 6/10/14 indicates that there are no other residents using wedges.
- 3) Only covered wedges will be used and they will be placed so that they do not touch the floor.
- 4) The DON will randomly check the room at least once per week and will report findings to the QA committee monthly.

06/30/14

From: Jackson Manor

6063642293

07/03/2014 13:21

#423 P.015/024

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

PRINTED: 06/24/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2014
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 253	Continued From page 2 and had not been aware of the concern with the foam wedges under Resident A's mattress. The DON stated the foam wedges should have been covered and should not be allowed to touch the floor. The DON stated she made rounds several times daily throughout the facility and had not identified the concerns.	F 253		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS  Based on the comprehensive assessment of a resident, the facility must ensure that --  (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and  (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  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 treatment and services were provided related to	F 322	1) All enteral feeding tube de-cloggers have been removed and will no longer be used. 2) This could affect any resident receiving enteral feeding and de-cloggers were removed from all of these residents. 3) The use of de-cloggers has been discontinued for all residents and other medical product labels will be checked to make sure that all products labeled single use are utilized appropriately according to industry standards. All nurses have been/will be individually in-serviced on the proper use of single use medical devices by 7/10/14. 4) The DON or her designee will check rooms randomly at least weekly for the presence of de-	



From: Jackson Manor

6063642293

07/03/2014 13:22

#423 P.017/024

PRINTED: 06/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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  C 06/10/2014
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 322	<p>Continued From page 4</p> <p>included Persistent Vegetative State, Convulsions, Brain Injury, Peptic Ulcer, and Dysphagia with Gastrostomy Tube Placement.</p> <p>Observation conducted on 06/10/14 at 9:16 AM revealed an item identified on the packaging as an "Enteral Feeding Tube DeClogger" on the windowsill of Resident B's room. The packaging was opened and a dried tan substance was observed on the device.</p> <p>2. Record review revealed the facility admitted Resident C on 03/26/13, with diagnoses that included Cerebrovascular Accident, Diabetes Mellitus, and Dysphagia with Gastrostomy Tube Placement. Resident C had a physician's order dated 05/01/14, for Nepro (a therapeutic nutritional supplement) to be delivered at 40 milliliters an hour via a gastrostomy tube.</p> <p>Observation on 06/10/14 at 9:25 AM revealed Resident C was in bed and the nutritional supplement was administered in accordance with physician's orders. Continued observation revealed two opened packages lying on the overbed table that contained "Enteral Feeding Tube DeClogger[s]" that were available for use.</p> <p>Interview conducted with Registered Nurse (RN) #1 on 06/10/14 at 3:24 PM revealed a "DeClogger" was used when a G-tube was clogged. RN #1 stated she inserted the "DeClogger" into the G-tube and when the G-tube became unclogged she removed the "DeClogger" and cleaned the "DeClogger" with water. Interview revealed RN #1 did not know if the "DeClogger" could be reused. RN #1 stated she had never received an in-service by the facility on the "DeClogger."</p>	F 322		

From: Jackson Manor

6063642293

07/03/2014 13:22

#423 P.018/024

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

PRINTED: 06/24/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2014
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 322	<p>Continued From page 5</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #1 on 06/10/14 at 9:35 AM revealed the "DeClogger" could be reused as long as it was washed with soap and water. The LPN stated, "I don't know how long" the "DeClogger" could be used and stated, "We date them when we open the package."</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #2 on 06/10/14 at 3:34 PM revealed the facility did not have a policy or protocol on the use or cleaning of the "DeClogger." The LPN stated, "If I use it then I would clean it, and would use it again when I go back, but if someone else used it and had not cleaned it, then I would throw it away." The LPN revealed she cleaned the "DeClogger" with hot water and a paper towel.</p> <p>An interview conducted with the Assistant Director of Nursing (ADON) on 06/10/14 at 3:51 PM revealed the "DeCloggers" were for single use, but stated, "I would not use it for more than 24 hours without getting a clean one." Further interview revealed the ADON cleaned the DeClogger by running water on the tip end of the "DeClogger." The ADON stated the facility has never had an in-service on the use of "DeCloggers."</p> <p>The Director of Nursing (DON) stated in interview conducted on 06/10/14 at 2:50 PM that the nurses in the facility used the "DeClogger" when G-tubes became clogged. According to the DON, she was not aware of a specific amount of time a "DeClogger" could be used before it needed to be replaced and stated she thought they could be "used more than once as long as it was kept in the package," and stated the "DeClogger" should</p>	F 322		

From: Jackson Manor

6063642293

07/03/2014 13:23

#423 P.019/024

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

PRINTED: 06/24/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2014
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 322	Continued From page 6 not be used if it was out of the original packaging. The DON stated when she conducted daily rounds she looked at the "DeClogger[s]" to ensure staff had put dates on the package indicating when the package was opened. The DON revealed the facility had not provided staff an in-service related to the "DeCloggers" and stated the facility only used one size "DeClogger." Further interview revealed the DON was not aware the G-tube required an appropriate sized "DeClogger."	F 322			
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 (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to 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	F 441	1) All enteral feeding tube de-cloggers have been removed and will no longer be used. 2) This could affect any resident receiving enteral feeding and de-cloggers were removed from all of these residents. 3) The use of de-cloggers has been discontinued for all residents and other medical product labels will be checked to make sure that all products labeled single use are utilized appropriately according to industry standards. All nurses have been/will be individually inservised on the proper use of single use medical devices by 7/10/14.		

From: Jackson Manor

6063642293

07/03/2014 13:24

#423 P.020/024

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

PRINTED: 06/24/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2014
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 441	<p>Continued From page 7</p> <p>direct contact will transmit the disease.</p> <p>(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, record review, and interviews it was determined the facility failed to maintain an effective infection control program to help prevent the development and transmission of disease for two (2) of twelve (12) residents (Residents B and C). Observation on 06/10/14 at 9:16 AM revealed a used and soiled "Enteral Feeding Tube DeClogger" (device used to achieve patency of a tube that has become clogged with semi-solid formula) was in an open and soiled plastic container on the window sill beside Resident B's bed. In addition, observation on 06/10/14 at 9:25 AM revealed two opened packages that contained "Enteral Feeding Tube DeClogger[s]" on Resident C's overbed table. Review of the label for the "DeClogger" revealed the device was intended for single use.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Infection Control," (not dated) revealed its purpose was to establish guidelines to follow in the prevention and spread of contagious, infectious, or</p>	F 4414)	<p>The DON or her designee will check rooms randomly at least weekly for the presence of de-cloggers and for the proper use of other medical devices. She will report her findings monthly to the QA committee.</p>	7/10/14	

From: Jackson Manor

6063642293

07/03/2014 13:24

#423 P.021/024

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

PRINTED: 06/24/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2014
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 441	<p>Continued From page 8</p> <p>communicable diseases. The objective of the policy was to ensure a sanitary environment was provided for personnel, residents, and visitors; and to prevent the spread of communicable diseases.</p> <p>Review of the facility's policy titled, "Gastrostomy Tube Changes-Routine Site Care," (not dated) revealed that a gastrostomy tube (G-tube) may be changed by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) if the device became dislodged or occluded after it had been initiated by the physician. However, the policy did not address the use of the "DeClogger" for use with a clogged gastrostomy tube.</p> <p>Review of the manufacturer's recommendations titled, "Enteral Feeding Tube DeClogger," (not dated) revealed the DeClogger was used to declog enteral feeding tubes and should be used every week to maintain unimpeded flow of an enteral formula. The "DeClogger" was also to be used to achieve patency of a tube that had become clogged with semi-solid formula. According to the policy, the "DeClogger" should be disposed of after a single use. Further review of the recommendations revealed the size of the gastric tube must be determined in order to select the appropriate size "DeClogger."</p> <p>1. Record review revealed the facility admitted Resident B on 04/12/96, with diagnoses that included Persistent Vegetative State, Convulsions, Brain Injury, Dysphagia, and Gastrostomy Tube (G-tube).</p> <p>On 06/10/14 at 9:16 AM, observation revealed an item identified as an "Enteral Feeding Tube DeClogger" on the windowsill of Resident B's</p>	F 441			

From: Jackson Manor

6063642293

07/03/2014 13:25

#423 P.022/024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED 06/24/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2014
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 441	<p>Continued From page 9</p> <p>room. The packaging was opened and a dried tan substance was observed on the device.</p> <p>2. Record review revealed the facility admitted Resident C on 03/26/13, with diagnoses that included Cerebrovascular Accident, Diabetes Mellitus, End Stage Renal Disease, Dysphagia, and Gastrostomy Tube Placement. Review of physician's orders dated 05/01/14 revealed the physician had requested staff to administer Nepro (therapeutic nutritional supplement) to Resident C by means of a G-tube at 40 milliliters an hour.</p> <p>Observation on 06/10/14 at 9:25 AM revealed Resident C had a tube feeding infusing at 40 milliliters an hour by means of a gastrostomy tube. Continued observation revealed two open packages that contained soiled "DeCloggers" on the resident's overbed table that were available for use.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 06/10/14 at 3:24 PM revealed she used a "DeClogger" if a G-tube became clogged, and cleaned it after every use. RN #1 stated the "DeClogger" could be used multiple times after it had been washed and was not aware the manufacturer's recommendation was for staff to use the "DeClogger" once and then discard. RN #1 stated, "We [staff] are required to clean it [DeClogger] after using it," and added if "anything" was on the device, she would get a new one and not reuse the soiled device. Further interview revealed the facility had not provided an in-service to the RN related to the use of the "DeClogger."</p> <p>An interview conducted with Licensed Practical</p>	F 441		

From: Jackson Manor

6063642293

07/03/2014 13:26

#423 P.023/024

PRINTED: 06/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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  C 06/10/2014
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 441	<p>Continued From page 10</p> <p>Nurse (LPN) #1 on 06/10/14 at 9:35 AM revealed the "DeClogger" could be reused as long as it was "washed" with soap and water.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #2 on 06/10/14 at 3:34 PM revealed the facility did not have a policy or protocol related to the use of the "DeClogger." LPN #2 stated if she used the device, she would clean it and use it again. However, according to LPN #2, if someone else had used the "DeClogger" and had not cleaned it, she would dispose of the device.</p> <p>An interview conducted with the Assistant Director of Nursing (ADON) on 06/10/14 at 3:51 PM revealed the "DeClogger" was for single use, and stated, "If used on a resident I wouldn't use it more than 24 hours." Further interview with the ADON revealed the "DeClogger" was to be cleaned by rinsing the tip with water and then drying with a paper towel. The ADON stated the facility had not provided staff an in-service on the use of "DeClogger[s]."</p> <p>An interview conducted with the Director of Nursing (DON) on 06/10/14 at 2:50 PM revealed, "Nurses use the DeClogger if a G-tube is clogged." The DON stated she was not aware the manufacturer recommended single use of the "DeClogger" and stated she thought staff could use them more than once as long as they were kept in the package. The DON stated she conducted daily rounds to observe for concerns related to resident care, including infection control issues, and looked at the "DeClogger[s]" at that time to ensure the package had been dated as to when it was opened. Further interview with the DON revealed the facility only had one size of "DeClogger[s]" and she was unaware the</p>	F 441			

From: Jackson Manor

6063642293

07/03/2014 13:26

#423 P.024/024

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

PRINTED: 06/24/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2014
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 441	Continued From page 11 manufacturer recommended that the size of the gastric tube be determined in order to select the appropriate size "DeClogger." The DON acknowledged the facility had never had an in-service related to the use of "DeClogger[s]."	F 441		