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

RECEIVED
MAY 18 2012
Division of Health Care
Southern Enforcement Branch

PRINTED: 05/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 A standard health survey was conducted on 04/22-24/12. Deficient practice was identified with the highest scope and severity at "E" level. An abbreviated standard survey (KY18169) was also conducted at this time. The complaint was unsubstantiated with no deficient practice identified. (All stated times were Eastern Standard Time.)	F 000	Preparation and execution of this plan of correction does not constitute 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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when	F 164	F 164 PRIVACY/CONFIDENTIALITY OF RECORDS Fair Oaks Health Systems to determine that the resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. Fair Oaks Health Systems to determine that the resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/17/2012

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 164	Continued From page 1 release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Resident's Bill of Rights, the facility failed to ensure personal privacy was provided for one of twenty-four sampled residents (Resident #10). Observation on 04/23/12, at 3:26 PM, revealed Licensed Practical Nurse (LPN) #3 and Certified Nursing Assistants (CNAs) #4 and #5 closed the door but failed to close the privacy curtain when they provided personal care to Resident #10. Observation revealed Resident #10's back and buttock area were visible/exposed when the roommate and family member opened the door and attempted to enter the room. The findings include: Review of the facility's Resident's Bill of Rights (not dated) revealed "residents shall be assured of at least visual privacy in multi-bedrooms." The Resident Bill of Rights also revealed "each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality including privacy in treatment and in care for personal care needs." Observation of incontinence care and a skin assessment of Resident #10 was conducted on 04/23/12, at 3:26 PM. LPN #3, CNA #4, and CNA #5 were observed to enter Resident #10's room and close the door to the room in order to provide the personal care. However, the staff failed to	F 164	Fair Oaks Health Systems to determine that the facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Criteria 1: Administrative nursing observations conducted on 5/16/12 - 5/23/12 have determined that Resident #10 is provided privacy during personal care. Criteria 2: Administrative nursing observations conducted on 5/16/12 - 5/23/12 have determined that residents are provided privacy during personal care. Criteria 3: LPN#3 has received in-service education provided by the DON/Director of Clinical Services on May 17, 2012 on the provision of privacy during personal care including but not limited to pulling the privacy curtains completely and shutting the door. CNA#4 and CNA#5 have received in-service education provided by the DON/Director of Clinical Services on May 17, 2012 on the provision of privacy during personal care including but not limited to pulling the privacy curtains completely and shutting the door. Facility Licensed Nursing Staff have received in-service education provided by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 164	Continued From page 2 close the privacy curtain around the bed of Resident #10 and as a result Resident #10's back and buttock area were exposed to the resident's roommate and family member when they attempted to enter the room from the hallway. Interview on 04/23/12, at 3:55 PM, with LPN #3 revealed he/she and CNAs #4 and #5 entered Resident #10's room and shut the door to provide incontinence care and perform a skin assessment. LPN #3 acknowledged he/she should have closed the privacy curtain before he/she began the skin assessment to ensure Resident #10 was not exposed if the door to the room was opened. Interview on 04/23/12, at 4:22 PM, with CNAs #4 and #5 revealed they had shut the door to provide privacy for incontinence care and the skin assessment but had not closed the privacy curtain. CNA #4 and CNA #5 acknowledged the privacy curtain should have been closed to ensure Resident #10 was not exposed if the room door was opened. Interview on 04/24/12, at 4:05 PM, with the Director of Nursing (DON) revealed that it is expected that staff provide privacy by closing the door and closing the privacy curtain for all care provided if any body part will be exposed.	F 164	the DON/Director of Clinical Services on May 9, 2012 on the provision of privacy during personal care including but not limited to pulling the privacy curtains completely and shutting the door. Facility State Registered Nursing staff have received in-service education provided by the DON/Director of Clinical Services on May 10, 2012 on the provision of privacy during personal care including but not limited to pulling the privacy curtains completely and shutting the door. Criteria 4: The CQI indicator for the monitoring of resident privacy will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Clinical services and Director of Nursing. Criteria 5: May 25, 2012	5/25/12
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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.	F 241	F241 DIGNITY AND RESPECT OF INDIVIDUALITY Fair Oaks Health Systems to determine 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 or her individuality.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTH SYSTEMS, LLC	1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629

(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 241	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy the facility failed to promote care for residents in a manner and environment that maintained or enhanced each resident's dignity for one of twenty-four sampled residents (Resident #4) and three unsampled residents (unsampled Residents #25, #26, and #27). Observation of the evening meal service on 04/22/12, revealed staff stood at the resident's bedside while assisting the resident with meals. The findings include: The facility failed to provide a policy that directed staff of the proper position to maintain during feeding a resident. Interview with the Administrator on 04/23/12, at 3:00 PM, revealed the facility utilized the Mosby Textbook for Long Term Care Nurse Assistant Manual, 6th Edition, 2011, to direct staff on acceptable standards of practice. A review of the manual revealed staff was to sit facing the resident when providing assistance with meals to demonstrate staff has time for the resident. In addition, according to the manual sitting provides a more relaxed atmosphere, and by facing the resident staff could determine if the resident had any problems with swallowing. 1. Observation of the evening meal on 04/22/12, at 6:15 PM, revealed CNA #1 entered unsampled Resident #25's room to assist the resident with the meal. Observation revealed CNA #1 stood at the resident's bedside during the meal.	F 241	Criteria 1: Administrative nursing and Dietary observations conducted on 5/16/12 -5/24/12 have determined that resident dignity is maintained with staff seated while providing feeding assistance for residents #4, 25, 26, and 27. Criteria 2: Administrative nursing and Dietary observations conducted on 5/16/12 – 5/24/12 has determined that resident dignity is maintained with staff seated while providing feeding assistance for residents. Criteria 3: A Feeding Proper Position Policy was written on May 9, 2012 to determine that when staff are providing assistance with meals they are to sit facing the resident, thus staff could provide a more relaxed atmosphere and also determine if the resident had any problems with swallowing for all residents. Inservice education was provided for CNA #1 and CNA#2 on May 17, 2012 on the Feeding Proper Position Policy and maintaining resident dignity during meal service including but not limited to staff of the proper position to maintain while providing feeding assistance as presented by Director of Nursing and Director of Clinical Services. Inservice education was provided for Facility Licensed Nursing Staff on May 9, 2012 on the Feeding Proper Position Policy and maintaining resident dignity during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 241	Continued From page 4 Further observation revealed at the completion of unsampled Resident #25's meal, CNA #1 exited the room, obtained another resident tray from the hall cart, and entered the room of unsampled Resident #26 at 6:32 PM. CNA #1 stood at the resident's bedside while she assisted/fed unsampled Resident #26. CNA #1 acknowledged in interview conducted on 04/22/12, at 7:45 PM, staff should sit and face the resident when assisting/feeding residents. CNA #1 stated chairs were not available in every resident room so staff had to stand to feed residents their meals. 2. Further observation of the evening meal on 04/22/12, at 6:30 PM, revealed CNA #2 was observed standing at Resident #4's bedside while she fed Resident #4 the evening meal. Continued observation of the evening meal on 04/22/12, revealed CNA #2 entered the room of unsampled Resident #27 at 6:50 PM, and was observed to stand during the meal and while she fed unsampled Resident #27. Interview with CNA #2 on 04/22/12, at 7:40 PM, revealed staff should sit to feed residents. CNA #2 stated unsampled Resident 27's family member was sitting in the chair at the resident's bedside and another chair was not available. Interview on 04/23/12, at 10:00 AM, with the Director of Nurses (DON) revealed staff should be seated and at eye level of the resident while feeding a resident.	F 241	meal service including but not limited to the proper position to maintain while providing feeding assistance as presented by Director of Nursing and Director of Clinical Services. Inservice education was provided for Facility State Registered Nursing Staff on May 10, 2012 on the Feeding Proper Position Policy and maintaining resident dignity during meal service including but not limited to the proper position to maintain while providing feeding assistance as presented by Director of Nursing and Director of Clinical Services. Criteria 4: The CQI indicator for the monitoring of resident dignity during meal service will be utilized monthly x 2 months then quarterly as per established CQI calendar under the supervision of the Director of Nursing and Director of Clinical Services. Criteria 5: May 25, 2012	5/25/12
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	F253 HOUSEKEEPING & MAINTENANCE SERVICES	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTH SYSTEMS, LLC	1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629

(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 5 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 record review it was determined the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Loose shower head brackets were observed in A and B Hall central baths. In addition, a wheelchair arm cover for Resident #13 was observed cracked and torn. The findings include: An interview conducted with the Maintenance Director on 04/24/12, at 3:40 PM, revealed the facility did not have a written Maintenance Policy. Additional interview revealed the facility had a maintenance form at each nurses' station for staff to document items in need of repair. The Maintenance Director stated he was required to make quarterly rounds of each wing and document items in need of repair on the facility maintenance forms. Further interview revealed the Maintenance Director checked the maintenance logs at each nurses' station daily and made rounds at least two times per week to identify items in need of maintenance/repair. Observations of A Hall and B Hall central baths conducted on 04/23/12, at 10:30 AM, revealed	F 253	Fair Oaks Health Systems to determine that the facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Criteria 1: The Loose shower head brackets observed in A and B Hall central baths, and the wheelchair arm cover for Resident #13 have been repaired/replaced by maintenance on 4/24/12. Criteria 2: An inspection was conducted by facility Administrator and Director of Maintenance of all resident rooms, common areas, and resident wheel chairs on May 18, 2012 to identify necessary repairs. All areas have been prioritized and scheduled for completion. Criteria 3: A facility Maintenance Program Policy was written on May 9, 2012 to determine that physical plant and equipment is maintained, in proper repair, and in good working condition at all times. Maintenance staff have received inservice education on the facility Maintenance Program Policy and the need to routinely inspect resident rooms, common areas and wheel chairs to identify and address all necessary repairs as provided by Director of Clinical Services, and Administrator on May 15, 2012. Facility Licensed Nursing staff have received inservice education on the facility Maintenance Program Policy and need to routinely inspect resident rooms, common areas and wheel chairs to identify and address all necessary repairs as provided by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTH SYSTEMS, LLC	1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629

(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 6 the resident shower head brackets were loose and not firmly attached to the wall. Observation of the wheelchair for Resident #13 conducted during an environmental tour on 04/24/12, at 3:40 PM, revealed the wheelchair arm was cracked/torn. A review of the A, B, and C Hall maintenance logs revealed no evidence the shower head brackets or the wheelchair arm for Resident #13 had been identified to need maintenance/repair. A review of the most recent quarterly maintenance forms completed by the Maintenance Director dated 02/02/12, revealed no evidence the loose shower brackets or the wheelchair arm for Resident #13 had been identified to need repair.	F 253	Director of Clinical Services, and Administrator on May 9, 2012. Facility Non-Licensed Nursing staff have received inservice education on the facility Maintenance Program Policy and need to routinely inspect resident rooms, common areas and wheel chairs to identify and address all necessary repairs as provided by Director of Clinical Services, and Administrator on May 10, 2012. Criteria 4: The CQI indicator for monitoring of the facility general environment and equipment will be utilized monthly x 2 months and then every six months thereafter under the supervision of the Administrator. Criteria 5: May 25, 2012	5/25/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and facility policy, it was determined the facility failed to	F 315	F315 NO CATHETER, PREVENT UTI, RESTORE BLADDER Fair Oaks Health Systems to determine that based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Criteria 1: Administrative Nursing observations conducted on 5/16/12 – 5/24/12 indicate that residents #4 and #5 are provided catheter care in accordance with infection control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 315	Continued From page 7 provide appropriate treatment and services to prevent urinary tract infections for two residents (Residents #4 and #5) in the selected sample of twenty-four residents. Observations during the provision of indwelling catheter care for Residents #4 and #5 revealed Certified Nurse Aide (CNA) #3 failed to provide catheter care in a proper manner and cleansed the indwelling catheter tubing toward the insertion site of the resident's indwelling urinary catheter. The findings include: A review of the facility's policy titled Care of Indwelling Catheter (revised 03/2012) revealed catheter care would be provided every day and as needed. The policy directed staff to cleanse at least the first two inches of the catheter closest to the insertion site plus cleanse the perineal area with soap and water or premoistened wipes. The policy failed to direct staff regarding the accepted standard of practice of cleansing in a downward motion and cleansing the catheter tubing away from the insertion site in an effort to decrease the possibility of contaminating the catheter insertion site with bacteria. Observation on 04/23/12, at 10:45 AM, revealed CNA #3 used premoistened wipes to provide catheter care for Resident #4. CNA #3 cleansed Resident #4's perineal area with the premoistened wipes using downward strokes. The CNA wiped the catheter tubing toward the catheter insertion site when she cleansed the catheter tubing. CNA #3 failed to cleanse the catheter tubing in an outward motion from the catheter insertion site when she cleansed the catheter tubing in order to decrease the possibility	F 315	standards of practice and the revised Care of Indwelling Catheter policy. Criteria 2: Administrative Nursing observations conducted on 5/16/12 – 5/24/12 indicate that all residents are provided catheter care in accordance with infection control standards of practice and the revised Care of Indwelling Catheter policy. Criteria 3: The facility's policy titled Care of Indwelling Catheter has been revised on May 9, 2012 to direct staff regarding the accepted standard of practice of cleansing in a downward motion and cleansing the catheter tubing away from the insertion site in an effort to decrease the possibility of contaminating the catheter insertion site with bacteria. CNA #3 has received inservice education on the provision of catheter care; the accepted standard of practice of cleaning in a downward motion and cleansing the catheter tubing away from the insertion site in an effort to decrease the possibility of contaminating the catheter insertion site with bacteria; and handwashing/ changing of gloves in accordance with infection control standards of practice and the revised Care of Indwelling Catheter policy as provided by the Director of Nursing and Director of Clinical Services on May 17, 2012. Facility State Registered Nursing Staff have received inservice education on the provision of catheter care; the accepted standard of practice of cleaning in a downward motion and cleansing the catheter tubing away from the insertion site in an effort to decrease the possibility of contaminating the catheter insertion site	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 315	Continued From page 8 of contamination. Further observation on 04/23/12, at 11:35 AM, revealed CNA #3 provided catheter care for Resident #5. CNA #3 used premoistened wipes to provide catheter care for Resident #5. CNA #3 was observed to wipe/cleanse the catheter tubing toward the catheter insertion site. An interview on 04/23/12, at 11:50 AM, with CNA #3 revealed she was knowledgeable of cleansing the resident with downward strokes when providing catheter care. CNA #3 stated she was not aware of any particular way to cleanse the catheter tubing except to just clean it with the wipes. Interview on 04/23/12, at 10:00 AM, with the DON revealed staff should always cleanse the catheter tubing by cleansing the tubing away from the resident and cleanse the perineal area using downward strokes.	F 315	with bacteria; and handwashing/ changing of gloves in accordance with infection control standards of practice and the revised Care of Indwelling Catheter policy as provided by the Director of Nursing and Director of Clinical Services on May 10, 2012. Facility Licensed Nursing Staff have received inservice education on the provision of catheter care; the accepted standard of practice of cleaning in a downward motion and cleansing the catheter tubing away from the insertion site in an effort to decrease the possibility of contaminating the catheter insertion site with bacteria; and handwashing/ changing of gloves in accordance with infection control standards of practice and the revised Care of Indwelling Catheter policy as provided by the Director of Nursing and Director of Clinical Services on May 9, 2012. Criteria 4: The CQI indicator for the monitoring of Peri-care / Catheter care and Handwashing will be utilized monthly x 2 months and then quarterly in accordance with the established CQI calendar under the supervision of the Director of Nursing. Criteria 5: May 25, 2012	5/25/12
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 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, interviews, and a review	F 322	F322 NG TREATMENT/SERVICES RESTORE EATING SKILLS Fair Oaks Health Systems to determine that based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 9 of the facility's policy/procedure, it was determined the facility failed to ensure appropriate treatment and services were provided to one of twenty-four sampled residents (Resident #29) related to gastrostomy tubes. Observation revealed staff failed to verify proper placement of the gastrostomy tube prior to administration of medications. The findings include: A review of the facility's Enteral Tube Medication Administration policy (no date) revealed that all enteral tubes were required to be flushed with at least 30 milliliters of water before administering and after all medications have been administered. However, the policy failed to include steps for verification of the gastrostomy tube (G-tube) placement prior to medication administration. A review of the Tube Feedings policy (no date) revealed G-tube placement would be verified by inserting 30 cubic centimeters (cc) of air into the G-tube while holding the stethoscope over the epigastrium to listen for a gurgling sound prior to administering tube feedings to a resident. Observation of a medication pass for Resident #29 on 04/22/12, at 5:40 PM, revealed Registered Nurse (RN) #1 failed to verify placement of the G-tube prior to the administration of 200 milligrams (mg) of Guaifenesin (decongestant), 200 mg of Labetalol (anti-hypertensive), 300 mg of Gabapentin (anti-seizure), 20 mg of Lisinopril (anti-hypertensive), 60 mg of Fexofenadine (antihistamine), 50 mg of Dantrolene (muscle relaxant), 0.3 mg of Clonidine HCL	F 322	nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Criteria 1: Verification of g-tube placement is completed before medication administration for resident #29 on 5/16/12 – 5/24/12. Criteria 2: An audit of all residents with orders for G-tube medications was completed by the DON and Director of Clinical services on May 16, 2012 to determine that medication are administered after verification of g-tube placement. Criteria 3: The facility's Enteral Tube Medication Administration policy was revised to include steps for verification of the gastrostomy tube (G-tube) placement prior to medication administration on May 9, 2012. Registered Nurse (RN) #1 has received inservice education on May 10, 2012, on the need to verify g-tube placement before medication administration in accordance with revised facility policy. Facility Licensed Nursing Staff have received inservice education on May 9, 2012, on the need to verify g-tube placement before medication administration in accordance with revised facility policy. Criteria 4: The CQI indicator for the monitoring of compliance with g-tube med pass in accordance with MD orders to determine g-tube placement before medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 10 (anti-hypertensive), 20 mg of Isosorbide (for angina), 10 cc of Amantadine (anti-Parkinson's), 20 cc of Docusate Sodium (stool softener), 20 mg Lasix (diuretic), and 30 cc of water. An interview with RN #1 on 04/22/12, at 5:50 PM, revealed the RN had been trained to verify G-tube placement by listening to abdominal sounds with a stethoscope after inserting air into the resident's G-tube. The RN acknowledged she should have verified placement of the G-tube prior to the administration of the medications, but stated she "forgot." Interview with the Director of Nursing (DON) on 04/24/12, at 5:00 PM, revealed the facility's Enteral Tube Medication Administration policy did not include specifics regarding the verification of the G-tube prior to medication administration. However, the DON stated the nurses should verify the G-tube placement prior to administering medications as described in the facility's Tube Feedings policy and in accordance with standards of nursing practice.	F 322	administration will be utilized monthly x 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Nursing and Director of Clinical services. Criteria 5: May 25, 2012	5/25/12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS Fair Oaks Health Systems to determine that drugs and biological used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 431	Continued From page 11 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to label, date, and store all drugs and biologicals in accordance with currently accepted professional principles. Observation of the facility medication storage areas revealed medications that exceeded the recommended expiration dates were available for resident use and a bottle of Dilantin (anti-seizure medication) was stored with the prescription label partially torn and removed. In addition, one bottle of eye drops and one vial of insulin were opened and available for use; however, the medications were not dated	F 431	proper temperature controls, and permit only authorized personnel to have access to the keys. Criteria 1: The expired medication identified in the EDK (Emergency Drug Kits) stored in the A and B hall medication Room; the bottle of Dilantin Suspension for Resident #27; and the undated Liquitears eye drops for Resident #30 and the Lantus insulin for Resident #31 have been removed and replaced as indicated on April 24, 2012. Criteria 2: Fair Oaks Health Systems' EDKs have been inspected on May 22, 2012 by the pharmacy and Administrative Nursing Staff to determine that all medications have not passed the expiration dates. All Eye drops and Insulin vials have been inspected on May 22, 2012 by Director of Clinical Services and Pharmacy Consultant to determine that they are correctly dated when opened. All Liquid medication labels have been inspected on May 22, 2012 by Director of Clinical Services and Pharmacy Consultant to determine that they are intact. Criteria 3: Medication Administration staff have received inservice education by the Director of Clinical Services on May 9, 2012 to include but not be limited to: the monitoring of EDK medication expiration dates; dating of multi-use meds upon opening; and inspection of liquid med labels to determine that they are intact.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 431	Continued From page 12 to indicate the date the bottle/vial was opened. The findings include: A review of the Medication Expiration Dating policy (no date) revealed eye drops were required to be dated when opened and discarded 90 days after being opened. The policy further noted insulin vials were also required to be dated when opened and discarded 30 days after being opened. The policy did not include information related to inspection of medication labels, or discarding/reporting of expired medications and replacement of labels. The facility did not provide a policy regarding expired or labeling medications. Observation on 04/24/12, at 2:15 PM, of the Emergency Drug Kit stored in the A and B Hall medication room revealed Aspirin Rectal Suppository 300 milligrams (mg) was stored in the kit and contained an expiration date of March 2011. Further observations of the medication carts on A and B Hall revealed Dilantin Suspension 2 mg/50 ml for Resident #27 was stored in a medication drawer with the prescription label partially torn and removed. The bottle was also noted to have a dried orange substance down the side of the bottle. In addition, Liquitears 1.4% ophthalmic drops for Resident #30 was stored in a medication drawer; however, the eye drops were not dated to indicate the date the medication had been opened. Observation of the C and D Hall medication refrigerator on 04/24/12, at 3:30 PM, revealed one opened vial of Lantus 100 U/ml Insulin for Resident #31. However, the medication was not	F 431	Criteria 4: The Pharmacy Consultant will review EDK expiration dates monthly to determine that all meds are replaced prior to reaching expiration; will inspect multi-use medications to determine that they have been correctly dated upon opening; and will inspect liquid medications to determine labeling is intact with monthly consulting visits. Criteria 5: May 25, 2012	5/25/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 431	Continued From page 13 dated to indicate the date the medication had been opened. Interview with Licensed Practical Nurse (LPN) #4 on 04/24/12, at 2:25 PM, revealed she or the nurses were responsible to clean the spills from the liquid bottles immediately and to report any problems with prescription labels to the pharmacy. LPN #4 stated she did not know why the label had not been replaced on the Dilantin bottle. Interview conducted with Unit Manager #1 on 04/24/12, at 2:30 PM, revealed she was responsible to check the emergency drug kit for expired medications. The Unit Manager stated she had not checked the emergency drug kit and had not identified that the expired Aspirin Rectal Suppository was still available for resident use. Interview conducted on 04/24/12, at 5:00 PM, with the Director of Nurses (DON) revealed the nurses or Certified Medication Tech (CMT) were responsible to clean the medication bottles/carts and to report any problems with medication labels to the pharmacy. The DON stated the Unit Managers or pharmacist were responsible to check for expired medications in the emergency drug kit. The DON further stated eye drop medications and Insulin vials were to be dated when opened by the nurses or CMT.	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	F465 SAFE/FUNTIONAL/SANITARY/ COMFORTABLE ENVIROMENT Fair Oaks Health Systems to determine that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 465	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide a functional and sanitary environment for residents, staff, and the public. Gutters for the A Wing of the building were observed to be clogged with leaf litter/debris. The findings include: An interview conducted with the Maintenance Director on 04/24/12, at 3:40 PM, revealed the facility did not have a written maintenance policy. According to the Maintenance Director, the facility gutters were cleaned annually when the facility started doing yard maintenance. Observation of the facility gutters on 04/24/12, at 3:40 PM, revealed the A Wing gutters were clogged with leaf litter/debris. An interview with the Maintenance Director revealed the Maintenance Director had identified the gutters were clogged and was going to clean the gutters during warm weather a few weeks prior but did not get to due to the weather changing. A review of the most recent quarterly maintenance forms completed by the Maintenance Director, dated 02/02/12, revealed the facility roof was checked and no problems were identified at that time.	F 465	Criteria 1: All Facility rain gutters have been inspected and cleaned by Maintenance staff on April 25, 2012. Criteria 2: Facility has installed gutter guards on all gutters to prevent gutters being clogged with leaf litter/debris by May 25, 2012. Criteria 3: Maintenance staff have received inservice education on May 15, 2012 by Administrator and the Director of Clinical Services on the yearly inspection/cleaning of facility Rain gutters. Criteria 4: The Facility Gutters will be inspected yearly by the Administrator to determine that they are free of debris. Criteria 5: May 25, 2012	5/25/12
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS	F 468	F 468 CORRIDORS HAVE FIRMLY SECURED HANDRAILS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTH SYSTEMS, LLC	1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629

(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 468	Continued From page 15 The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure corridors were equipped with firmly secured handrails. Handrails were observed loose and not firmly affixed to the walls on the A, B, and C Halls. The findings include: An interview conducted with the Maintenance Director on 04/24/12, at 3:40 PM, revealed the facility did not have a written Maintenance Policy. Additional interview revealed the facility had a maintenance form at each nurses' station for staff to document items in need of repair. Observations conducted on 04/22/12, at 4:50 PM, revealed loose handrails located on the A Hall across from resident room 4, loose handrails on the B Hall across from resident room 16, and on the C Hall near resident rooms 31 and 27. An interview conducted with the Maintenance Director on 04/24/12, at 3:40 PM, revealed the Maintenance Director made rounds two times per week and quarterly to identify concerns in need of repair. Additional interview with the Maintenance Director revealed he was not aware of the loose handrails. A review of current maintenance logs located on	F 468	Fair Oaks Health Systems to determine that the facility must equip corridors with firmly secured handrails on each side. Criteria 1: The handrails on the A, B, and C halls have been repaired by the maintenance staff on April 25, 2012. Criteria 2: Maintenance staff have inspected all facility handrails on May 22, 2012 and repaired any identified issues. Criteria 3: Maintenance staff and housekeeping staff have received inservice education on May 17, 2012 on the monthly inspection of facility handrails as provided by the Administrator and Director of Clinical Services. Criteria 4: The CQI indicator for the monitoring of facility handrails will be utilized monthly x 2 months, and then every 6 months thereafter under the supervision of the Administrator. Criteria 5: May 25, 2012	5/25/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185286		C 04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTH SYSTEMS, LLC	1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629

(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 468	Continued From page 16 the A, B, and C Halls revealed no evidence the loose handrails had been identified as needing maintenance/repair. Additional review of the quarterly maintenance form completed by the Maintenance Director on 02/02/12, revealed no evidence of problems with loose handrails.	F 468		

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

PRINTED: 05/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED
	185286		04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTH SYSTEMS, LLC	1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629

(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 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1989 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111(000) SMOKE COMPARTMENTS: Seven FIRE ALARM: Complete automatic fire alarm system SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system GENERATOR: Type II diesel generator A life safety code survey was initiated and concluded on 04/24/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	RECEIVED MAY 18 2012 Division of Health Care Southern Enforcement Branch	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in	K 025	K 025 LIFE SAFETY CODE STANDARD	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/17/2012

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185286	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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	Continued From page 1 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, the facility failed to maintain the fire/smoke barrier wall assemblies in the attic area. This deficient practice affected two of seven smoke compartments, staff, and approximately twenty residents. The facility has the capacity for 128 beds with a census of 108 on the day of the survey. The findings include: During the Life Safety Code survey on 04/24/12, at 09:20 AM, with the Director of Maintenance (DOM), observation revealed a gap around the ductwork in the fire/smoke barrier wall in the attic area of the Zone B corridor. Penetrations of fire/smoke barrier walls must be sealed with an approved material to help prevent fire/smoke from spreading to other areas of the building in a fire situation. An interview with the DOM on 04/24/12, at 09:20 AM, revealed the DOM was aware fire/smoke barrier walls should be maintained. The DOM stated he was unaware this wall had not been maintained.	K 025	Fair Oaks Health Systems will determine that 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 Criteria 1: The fire/smoke barrier wall in the attic area of the Zone B corridor have been sealed with an approved material to help prevent fire/smoke from spreading to other areas of the building in a fire situation by Maintenance staff on April 24, 2012. Criteria 2: Maintenance staff have inspected all of the facility's fire/smoke barriers on 4/24/12 and 5/15/12, and repaired any identified issues. Criteria 3: Maintenance staff have received inservice education on monthly inspection and maintenance of facility fire/smoke barriers as defined per NFPA 101 (2000 Edition) in 8.3.2 and 8.3.6.1 as provided by the Administrator and Director of Clinical Services on May 15, 2012. Criteria 4: The CQI indicator for the monitoring of facility fire/smoke barriers will be utilized	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185286	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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	Continued From page 2 Reference: NFPA 101 (2000 Edition). 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.	K 025	monthly x 2 months, and then every 6 months thereafter under the supervision of the Administrator. Criteria 5: May 25, 2012	5/25/12
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050	K 050 LIFE SAFETY CODE STANDARD Fair Oaks Health Systems to determine that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185286		04/24/2012

NAME OF PROVIDER OR SUPPLIER
FAIR OAKS HEALTH SYSTEMS, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1 SPARKS AVENUE, P O BOX 740
JAMESTOWN, KY 42629

(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 050	Continued From page 3 varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 128 beds with a census of 108 on the day of the survey. The findings include: During the Life Safety Code survey on 04/24/12, at 9:40 AM, with the Director of Maintenance (DOM) a record review revealed the facility had not been performing fire drills at unexpected times and varying conditions on the third shift. From July 2011 to March 2012, third shift fire drills were conducted between 5:45 AM and 5:50 AM. An interview with the DOM on 04/24/12, at 9:40 AM, revealed the DOM was not aware fire drills should be conducted at different times throughout a shift.	K 050	fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Criteria 1 and 2: The facility reviewed and revised on May 10, 2012 its process of conducting fire drills at unexpected times to determine that staff are prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness for the safety of all residents and all staff. Criteria 3: All staff have received in-service education on May 10, 2012 by the Administrator and Director of Clinical Services on Fire Safety/ Conduct Fire drills to determine that staff are prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness for the safety of all residents and all staff. Criteria 4: The CQI indicator for the monitoring of facility Fire Drills will be utilized monthly x 3 months, and then every 6 months thereafter under the supervision of the Administrator. Criteria 5: May 25, 2012	5/25/12