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

PRINTED: 07/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING B. WING	C 06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	2323 CONCRETE ROAD CARLISLE, KY 40311

(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 Recertification Survey was conducted on 06/22/10 through 06/24/10. A Life Safety Code Survey was conducted 06/23/10. Deficiencies were cited with highest scope and severity of an "F". An Abbreviated Survey was conducted on 06/22/10 through 06/24/10 related to five (5) complaint investigations. The investigation of KY00014830, KY00014832, KY00014833 and KY00014834 revealed the allegations were found to be unsubstantiated. The investigation of KY00014831 revealed the ARO to be substantiated, with no deficiency cited.	F 000	RECEIVED JUL 27 2010 BY:	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	**TAG F 279** **483.20(d), 483.20(k)(1)** **Develop Comprehensive Care Plans** **Correction:** On the date of survey, a Comprehensive Care Plan had not been completed on Resident #3. A Comprehensive Care Plan has been developed for Resident #3 that addresses his mood and behaviors. **Identification of Residents:** All residents' have the potential to be affected by this practice. On June 23 and 24, 2010, The Assist Director of Nursing and the Care Plan Coordinator reviewed care plans for **ALL residents** in the facility, and no other residents were identified with incomplete Care Plans.	7/14/10 7/14/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Admin	7/27/10

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

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F 279	Continued From page 1 by: Based on interview and record review it was determined the facility failed to ensure a Comprehensive Plan of Care was developed for the needs of one (1) of nineteen (19) sampled residents (Resident # 3). The facility identified through the Minimum Data Set (MDS) assessment that Resident #3 had mood and behavior issues; however, a Comprehensive Plan of Care was not developed related to mood or behavior. The findings include: Review of the Resident Assessment Protocol Summary (RAPS), dated 08/06/09, revealed the facility assessed Resident #3 to have problems related to mood, as the resident exhibited behaviors of crying, sad expression, somatic and anxious complaints. Further review of the RAPS revealed the facility decided to proceed with care planning the resident for this behavior. However, no care plan was developed. Interview on 06/24/10 at 2:40 PM with Licensed Practical Nurse #5, MDS Coordinator revealed the care plan was updated from orders and notes. She further stated, "this is normal behavior for the resident. If the resident had a change or was cursing or hitting I would have thought to care plan the behavior. She continued stating, that Resident #3 had complaints of family dumping. During further interview she stated "there is no mood or behavior care plan on the initial or the updated care plan and I can' tell you why I did not proceed to the care plan" .	F 279	**Measures for Non-recurrence:** A member of the Care Plan Team (the Assistant Director of Nursing or designee) will review each care plan upon completion to assure that a Comprehensive Care Plan has been developed that addresses all areas triggered through the RAPS. **Monitoring of Corrective Action** The Care Plan Team will monitor the completeness of resident RAPS/Care Plans by reviewing care plans done each week for completeness of all areas triggered through the RAPS. This data will be accumulated and tabulated monthly, then reported to the Quality Assurance and Assessment Committee Quarterly for the next year.	

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K 000	INITIAL COMMENTS A Life Safety Code Survey was initiated and concluded on June 23, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found to not be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest Scope and Severity of an "F".	K 000	RECEIVED JUL 15 2010 BY:	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that an exit door utilized a proper unlocking system in case of fire or other emergency. This deficient practice affected one (1) of five (5) smoke compartments, staff and approximately twelve (12) residents. The facility has the capacity for one hundred and four (104) beds with a census of ninety-two (92) on the day of survey. The findings include: Observations during the Life Safety Code tour on June 23, 2010 at 10:00 AM, with the Director of Maintenance, revealed magnetic locking devices on the exterior exit doors of the Southwest Special Wing Unit. An interview with the Director	K 038	TAG K 038 NFPA 101 Life Safety Code **Corrective Measures** July 9, 2010 Maintenance installed a pull-stop mechanism on the lock to the exit doors of the Secure Unit. This mechanism will allow the lock to be immediately deactivated for egress and then immediately reactivated when the egress is completed. The device is located next to the door at a location that should not be easily activated by the residents, but easily activated by staff when needed. **Measures for Non-recurrence** These are the only exit doors in the facility that are locked at all times. No other doors shall be impacted. **Monitoring of Corrective Action** Maintenance will monitor the pull-stop mechanism for proper operation as a part of their fire safety monitoring program. This will be reported to the Safety Committee quarterly.	7/9/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/15/10

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K 038	Continued From page 1 of Maintenance, at that time, revealed the only way to release the doors in an emergency was to pull the fire alarm pull station. The Director of Maintenance stated a building inspector had approved this method of releasing the locking mechanisms. These types of locks are required to release if the fire alarm system does activate. However, there would not be a practical way to release the locks in case of a faulty fire alarm system or other emergency. Reference: NFPA 101 2000 edition 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) 19.2.2.2.5 Doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door.	K 038		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

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K 072	Continued From page 2 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. This deficient practice affected four (4) of five (5) smoke compartments, staff and approximately ninety- two (92) residents. The facility has the capacity for one hundred and four (104) beds with a census of ninety (92) on the day of survey. The findings include: During the Life Safety Code tour on June 23, 2010 at 8:50 AM with the Director of Maintenance, a linen cart and two (2) trash carts were observed in the Sunshine Garden corridor of the facility. An interview with the Director of Maintenance, at this time, revealed these carts were routinely left unattended when not in use throughout the day. The Director of Maintenance was also aware these items were required to be stored out of the corridors when not in use. Corridors are intended for means of egress, internal traffic and emergency use, not storage spaces. The Life Safety Code has specific requirements for storage spaces. These items would also limit the use of the hand rails by	K 072	TAG K 072 NFPA 101 Life Safety Code Standards **Corrective Measures** The linen carts and trash carts were removed from the Sunshine Garden Hallway when not in use. **Measures for Non-recurrence** Clean linens will be distributed to each room daily by nursing staff. Clean linen carts will be stored in the clean utility room. All trash and dirty linen carts must be taken to the areas of use and when not in use, must be stored in the dirty utility room. Refer to Addendum #1 - Memo posted for Nursing Staff regarding use of carts in the hallway. **Monitoring of Corrective Action** Director of Nursing and/or Assistant Director of Nursing will monitor the hallways daily for to assure compliance. In addition, hallway clearance will be monitored during safety rounds and reported to the Safety/Risk Management Committee monthly by nursing.	7/14/10

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K 072	Continued From page 3 occupants of the building when needed. Linen carts, trash carts, feeding pumps etc., were observed stored in the corridors throughout the facility during the survey.	K 072		