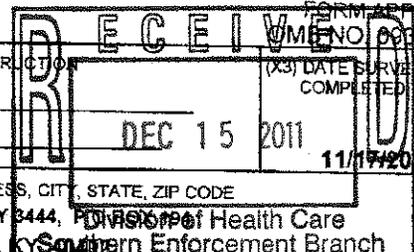


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2011

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 11/17/2011
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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 69 HIGHWAY 3444, DIVISION of Health Care ANNVILLE, Pa Southern Enforcement Branch
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 F 157 SS=D	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 11/15-17/11. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 000 F 157	<p>#1 Resident #6 family acknowledged notification of resident condition resulting in a change of treatment related to vomiting and a fever on 11-3-11.</p> <p>#2 DON reviewed 24 hour reports for past month as well as reports of all incidents for past 30 days to ensure that family and physician notification did occur. No issues were noted.</p> <p>#3 All licensed nurse staff will be re-educated on the facility policy related to Notification of Change by the DON and ADON and this will be completed by 12-15-11. This re-education will be repeated monthly for 3 months, then annually. All newly hired nurses will be educated during orientation.</p> <p>#4 The ADON will review all 24 hour reports, all new physician orders and all reports of</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pha Sullivan TITLE: Adm. (X5) DATE: 12-15-11

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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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 69 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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policies, the facility failed to ensure a family member was notified immediately of a significant change in health status for one of twelve residents. Resident #6 experienced a significant change in health status on 11/03/11. However, the facility failed to immediately notify the resident's family member and/or legal representative of the change in the resident's condition. The findings include: A review of the facility's Notification of Change Policy (dated 06/27/08) revealed facility staff was to notify the designated family member of a significant change in the resident's physical, mental, and psychosocial status and of the need to alter treatment, or commence a new form of treatment. A review of the medical record for Resident #6 revealed the facility admitted the resident on 04/07/07, with diagnoses of Status/Post Cerebral Vascular Accident (CVA), esophageal reflux, and senile dementia. A review of the nurse's notes dated 11/03/11, at 1:00 PM, revealed the resident had two episodes of vomiting and the resident's axillary temperature was 101 degrees Fahrenheit. The Licensed Practical Nurse (LPN) assigned to provide care for the resident on 11/03/11, contacted the resident's physician on 11/02/11, for a medication to control the resident's vomiting. Further review of the nurse's notes revealed the resident continued to have a temperature on the	F 157	Incidents to ensure that physician and family notification has occurred. This will be done weekly for 4 weeks then monthly for 3 months. These reviews will be presented to the facility QA Committee for review no less than quarterly. #5 Completion date	12-16-11

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 69 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 157	Continued From page 2 following day, 11/04/11, and the resident's oral intake was decreased. The resident's physician was contacted and prescribed an intravenous (IV) infusion of .45% Normal Saline. An interview was conducted with the resident's family member, who was also the resident's legal representative, on 11/15/11, at 10:00 AM. The resident's family member stated facility staff had not contacted her when Resident #6 became ill. The resident's family member stated facility staff was aware the family member wanted to be notified any time the resident experienced any change in condition and that telephone numbers were listed on the resident's medical record face sheet. An interview was conducted on 11/17/11, at 10:15 AM, with the LPN on duty when Resident #6 became ill. The LPN stated she was aware the resident's family member was to be notified of any change in the resident's condition. According to the LPN, she had failed to take the time to contact the resident's family member on 11/03/11, to inform them of a change in the resident's condition.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225	#1 DON interviewed staff related to the skin tears on Resident #7 on 3-7-11, 4-13-11 and 7-3-11 to investigate the origin of the skin tears and abrasion. These were completed on 12-13-11. There is no indication that abuse or neglect is involved. The resident care plan has been reviewed and	

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 69 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402	
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F 225	<p>Continued From page 3</p> <p>indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of policies, it was determined the facility failed to thoroughly investigate and report injuries of unknown origin to the required State Agencies for one of thirteen sampled residents. Resident #7 sustained skin tears on two separate occasions and an abrasion on another occasion. The facility could not provide documentation the</p>	F 225	<p>updated as indicated. This was completed by the MDS Coordinator on 12/13/11</p> <p>#2 All MD orders for past 30 days were reviewed by the ADON to identify any new treatments that may have been received related to injuries or unknown origin, skin tears, abrasions, etc, and these were then matched to the log of reports of incidents to determine if there were any instances when a report of the incident was not completed. ADON reviewed 24 hour reports for any noted injuries, abrasions etc. and matched these to reports of incidents to ensure all reports were completed as per our policy.</p> <p>#3 Licensed nurses were re-educated on the process for completing reports of incidents as well as the investigation of all incidents for quality assurance. This education was completed by DON and/or the ADON on</p>	

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 65 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 4 incidents had been investigated or reported to the State Agencies as required. The findings include: A review of the facility's policy entitled Incident Reporting (dated June 2006) revealed an Incident Report would be used by the facility for the investigation of any incident involving a resident. The policy also revealed an Incident Report would be filled out as soon as was practicable after an incident occurred, and the original copy would be provided to the Administrator or the Director of Nursing (DON) for review. The policy also revealed the Investigative Protocol would be completed for skin tears and injuries of unknown origin. A review of the facility's policy entitled Abuse Prohibition (undated) revealed the facility would report any suspected incident of abuse to the Adult Protection Agency and to the Licensure and Regulatory Agency immediately by phone or fax. The policy also revealed any act of mistreatment, occurrences, patterns, or trends that may constitute abuse should be reported and would be investigated. A review of the medical record for Resident #7 revealed the facility admitted the resident on 09/26/08, with diagnoses that included Alzheimer's Dementia, Malaise, Muscle Disuse Atrophy, Coronary Artery Disease, and Diabetes Mellitus. A quarterly Minimum Data Set (MDS) assessment for Resident #7 dated 11/04/11, revealed the resident required the total assistance of two persons to turn and reposition in bed.	F 225	12/5/11. This education will be repeated monthly for 3 months then annually. All newly hire nurse will be educated during orientation. #4 ADON will get copies of all physician orders to review, and will review the 24 hour reports to ensure that reports of incidents are completed per our policy. She will continue this practice weekly for 4 weeks then monthly for 3 months. ADON will report her findings to the facility QA Committee no less than quarterly. #5 Completion date	12/12/11	

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 69 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 5</p> <p>Observation of Resident #7 on 11/15/11, at 12:15 PM, revealed the resident was lying in bed on his/her back. A winged mattress (a mattress with padded and raised edges) was observed on the resident's bed. The resident did not respond when his/her name was called.</p> <p>A review of the nurse's notes for Resident #7 dated 03/07/11, at 5:00 PM, revealed the resident received a skin tear to the left outer forearm. The documentation also revealed the physician and responsible party had been notified. However, there was no evidence an incident report had been completed related to the skin tear.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 11/17/11, at 6:15 PM, revealed the LPN had provided care to Resident #7 on 03/07/11. The LPN stated she was aware she was responsible to complete an incident report on 03/07/11, after the incident occurred. However, the LPN acknowledged she had failed to complete an incident report related to the skin tear, and stated she did not know why she had not filled out the incident report.</p> <p>A review of the nurse's notes for Resident #7 dated 04/13/11, at 1:00 AM, revealed the resident had been observed to have a skin tear to the left upper arm.</p> <p>An interview conducted with LPN #3 on 11/17/11, at 6:45 PM, revealed the LPN had provided care to Resident #7 on 04/13/11, the day the skin tear was observed, and should have completed an incident report after the skin tear had been observed. The LPN acknowledged she should</p>	F 225			

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 69 HIGHWAY 3444, P O BOX 154 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 6</p> <p>have completed an incident report after the incident, and offered no explanation as to why she failed to complete the report.</p> <p>A review of the nurse's notes for Resident #7 dated 07/03/11, with no time documented on the nurse's note, revealed the resident had been observed to have an abrasion located on the inner right thigh.</p> <p>An interview conducted with LPN #2 on 11/17/11, at 6:25 PM, revealed the LPN had provided care to Resident #2 on 07/03/11, the day the abrasion was observed, and should have completed an incident report. The LPN stated she could not remember what had happened or why an incident report had not been completed.</p> <p>An interview conducted with the Assistant Director of Nursing (ADON) on 11/16/11, at 3:00 PM, revealed nurses were responsible to complete incident reports on any injury to a resident. The ADON stated she received and reviewed all incident reports after staff filled them out. The ADON also stated she entered the incidents in a log book and sent them to the Administrator and the DON. The ADON stated she had no record of incident reports being filled out for Resident #7 on 03/07/11, 04/13/11, or 07/03/11.</p> <p>An interview conducted with the DON on 11/17/11, at 6:30 PM, revealed nurses were expected to fill out an incident report for skin tears and also for abrasions. The DON confirmed the incident reports were forwarded to the ADON to enter into a log book and then to the Administrator. The DON stated she tracks and</p>	F 225			

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 69 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7 trends the reported incidents. An interview with the Administrator conducted on 11/17/11, at 7:00 PM, revealed nurses were responsible for completing the incident reports for abrasions and skin tears and to begin investigating to determine how the resident sustained the injury. The Administrator also stated after the nurse completed an incident report, the report would be forwarded to the ADON to be entered into a log book, and then forwarded to him and to the DON for review. The Administrator stated if there was no evidence of incident reports for Resident #7 for the reported dates the reports had probably not been completed as required.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, the facility failed to ensure policies developed to prohibit mistreatment, neglect, abuse, and misappropriation of resident property had been implemented for two of five employees (LPN #4 and SRNA #1) prior to employment. A review of personnel files revealed the facility failed to obtain a criminal background check and had not consulted the Nurse Aide Abuse Registry prior to the employment of Licensed Practical Nurse	F 226	#1 A criminal background check, license verification and a check of the nurse aide abuse registry was completed for LPN #4 on 11/28/11 by the DON. The detailed report for SRNA #1 was printed and placed in the employee record on 11/30/11 by Linda Bowling. #2 The employment records for all employees will be audited by	

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 69 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
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F 226	<p>Continued From page 8</p> <p>(LPN) #4 and State Registered Nurse Aide (SRNA) #1. The facility failed to ensure two of five employees' files (LPN #4 and SRNA #1) had an abuse registry and criminal background check completed prior to employment.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Abuse Prohibition" (not dated) revealed the facility was to determine the individual's status on the Kentucky Abuse Registry, perform a criminal background check on newly hired employees by requesting criminal record information from the Kentucky State Police Department or other approved governmental agencies, contact the Kentucky Board of Nursing to verify the employee had an active license and/or was in good standing for Licensed Nurse applicants, Certified Nursing Assistants, or Nursing Assistants, and to contact the appropriate licensing boards to determine if licensed health care professionals were in good standing.</p> <p>A review of employee files on 11/17/11 revealed:</p> <p>LPN #4 had been employed at the facility prior to her resignation in August 2011 and was rehired on 09/15/11. However, there was no evidence the facility had performed a criminal background check or a nurse aide/abuse registry background check of the employee prior to the employee's employment.</p> <p>SRNA #1 was hired on 10/19/11. A review of SRNA #1's employee file revealed the facility utilized "my Certiphi," an investigation information data collection system, to perform criminal</p>	F 226	<p>the administrator. This audit will be completed by 12/20/11, to ensure that the file includes the background checks, license verification, and nurse aide abuse registry check. If the company's new service, Certiphi, was used, the detailed report will be in the record.</p> <p>#3 The corporate policy regarding re-hires has been revised and the facility will perform a background check, nurse aide abuse registry check and license verification check regardless of previous employment. The facility HR department was educated on this change by the Administrator on 11/19/11. The HR department was also instructed to print the detailed report for the employee record from Certiphi.</p> <p>#4 The payroll clerk will audit all new employee records monthly for 6 months, then quarterly to ensure that all files include the</p>		

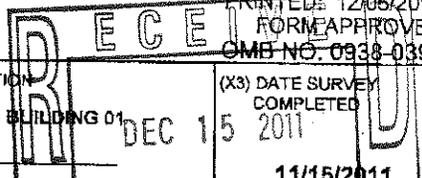
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F 226	Continued From page 9 background and nurse aide/abuse registry background checks of employees. However, the CNA's criminal background and nurse aide abuse status could not be determined by a review of the documentation provided. The report only revealed the check had been completed and contained no findings related to the inquiries. Interview with the Director of Nursing (DON) on 11/17/11, at 6:00 PM, revealed it was her responsibility to ensure abuse registry and criminal background checks were performed on all new hires. According to the DON, she had consulted with the facility's Human Resources (HR) Manager at the time of the LPN's reemployment and was informed that a new background check was not necessary. Interview with the HR Manager on 11/17/11, at 7:16 PM, revealed LPN #4 had been employed with the facility prior to her resignation in August 2011, and was rehired on 09/15/11. The HR Manager stated she was informed by the facility's corporate office it was not necessary to process another packet and complete a new background check if the employee had returned to the facility in less than 60 days.	F 226	detailed report from Certiphi beginning 12-15-11 and will report these audits to the facility QA committee no less than quarterly. #5 Completion date	12-20-11.	

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 69 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402
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K 000	INITIAL COMMENTS BUILDING: 01 PLAN APPROVAL: 1989 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V (III) SMOKE COMPARTMENTS: Five COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 11/15/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	The sprinkler system was inspected, tripped and reset on 11-29-11. The facility utilizes a computerized program (TELS) to assist the facility staff in monitoring tasks within the facility related to plant operations. The sprinkler	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>ChA. Lullum</i>	TITLE <i>Adm.</i>	(X6) DATE 11-15-11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2011
NAME OF PROVIDER OR SUPPLIER JACKSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 69 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
K 062	Continued From page 1 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain their sprinkler system by NFPA standards. This deficient practice affected five of five smoke compartments, staff, and all of the residents. The facility has the capacity for 51 beds with a census of approximately 50 on the day of the survey. The findings include: During the Life Safety Code tour on 11/15/11, at 11:30 AM, a record review with the Director of Maintenance (DOM) revealed an interior pipe inspection was performed on 07/08/06, by a contracted service. This inspection is required every five years. There was no record of a full flow trip test being performed. These inspections and reports help to maintain and ensure the sprinkler system reacts as intended in a fire situation. An interview with the DOM on 11/15/11, at 11:30 AM, revealed the DOM depended on the sprinkler contractor to maintain the sprinkler system to proper standards. Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined	K 062	system and sprinkler testing, the annual trip test, the full flow trip test and the internal inspection have been added to this program to ensure the facility staff is alerted to the dates these tests should be completed. The corporate regional director of plant operations will check the TELS report monthly to ensure that all tasks are completed as required. He will report on any lapses to the administrator for resolution. Completion date	12-5-11

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K 062	<p>Continued From page 2</p> <p>internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>9-1* General. This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of valves, valve components, and trim. Table 9-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance</p> <table border="0"> <tr> <td>Trip test</td> <td>Annually</td> </tr> <tr> <td>Full flow trip test</td> <td>3 years</td> </tr> </table>	Trip test	Annually	Full flow trip test	3 years	K 062		
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Full flow trip test	3 years							