

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

PRINTED: 09/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 09/09/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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

Based on the facility's acceptable Plan of Correction received on 08/23/15, the facility was deemed to be in compliance on 09/01/15 as alleged.

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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

An Abbreviated Survey investigating complaint KY00023540 was initiated on 07/27/15 and completed on 07/30/15. KY00023540 was substantiated with deficiencies cited.

F 241 483.15(a) DIGNITY AND RESPECT OF SS=D 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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, it was determined the facility failed to promote care in a manner which enhanced or maintained each resident's dignity for one (1) of four (4) sampled residents (Resident #3). Resident #3 did not receive showers as scheduled.

The findings include:

Review of the facility's policy titled, "Bathing", undated, revealed residents would be given two (2) "full" baths per week, according to their health status, and a partial or complete bed bath on other days.

Review of Resident #3's medical record revealed the facility re-admitted the resident on 7/30/14, with diagnoses which included Dementia, Chronic Pain, Coronary Artery Bypass Graft and Benign Prostatic Hypertrophy. Review of the Quarterly MDS dated 06/09/15, revealed the facility

F 000

Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents.

F 241

The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.

F241

Resident #3 received a shower with the assistance of a SRNA on 7/29/2015. The Staff Facilitator (SDC) provided education to SRNAs #8 and #9 on 8/6 and 8/7/2015, regarding giving baths/showers as scheduled per the care plan and communicating with their nurse should a resident refuse care. This education also included proper documentation of resident care provided.

All residents have the potential to be affected. Residents were visited by the Administrator on 8/18/2015 through 8/21/2015 to identify any other residents

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

8/23/15

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 241 Continued From page 1
assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed Resident #3 as requiring physical help of one (1) person for bathing.

Review of the Comprehensive Plan of Care revised 10/16/14 revealed the resident required assistance for bathing related to cognitive impairment, impaired mobility, and weakness. The goal stated the resident would be neat, clean, and odor free. The interventions stated the resident required two (2) person physical assist with bathing. Review of Resident #3's Care Guide revealed the resident was to receive physical assistance of two (2) persons for bathing.

Interview with Resident #3 on 7/28/15 at 12:30 PM, revealed the resident had not had received a shower in three (3) weeks. Per interview, Resident #3's shower was supposed to be on Wednesdays and Saturdays at 3:00 PM. However, Resident #3 stated when he/she asked for a shower, staff would tell the resident they would be back in a few minutes, but never came back or if they did they brought him/her a bag of wipes and told the resident to wash off with the wipes.

Interview, on 7/28/15 at 1:45 PM, with Certified Nursing Assistants (CNA's) #8 and #9 revealed they were both assigned to Resident #3 and working the hall together providing resident care. Continued interview revealed Resident #3 was to receive a shower on Wednesdays and Saturdays, but often refused the showers. Per interview, if residents refused their showers, it was to be

F 241 affected. Residents were interviewed regarding bathing/showering frequency. Residents unable to provide answers to the Administrator had their record reviewed for shower/bath frequency. Any concerns identified were addressed with staff and corrected at the time of the discussion with the resident.

All staff were re-educated 8/20/2015 - 08/23/2015 by the Staff Facilitator, QI Nurse, DON and/or Administrator with regard to ensuring all residents maintain good body hygiene by routine bathing/showering per their preferences. This education will be provided to all Agency staff and new employees during orientation.

The Bathing Plan developed through the QI Process, by the Person Centered Care Bathing Committee, is in the process of being implemented and will be fully implemented by 8/31/2015. Under this plan each resident was interviewed by Committee members regarding their preference for type of bath/shower, frequency of bath/shower and time of day to receive bath/shower. A schedule was developed to meet the residents' preferences, two shower aides have been identified by the DON to provide showers to the residents Monday through Saturday of each week, tub baths and bed baths will be

9/1/2015

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 241 Continued From page 2
documented on the bath flow sheet as a refusal and the nurse was to be notified.

Review of the facility's Documentation Survey Report (bath flow sheet) for July 2015 for Resident #3 revealed there was no documented evidence the resident had a shower or full bath from 07/19/15 to 07/28/15, a ten (10) day period, with no refusals documented during that time.

Interview, on 7/29/15 at 5:15 PM, with Licensed Practical Nurse (LPN) #7 who was assigned to Resident #3 revealed she was not aware the resident had not received a shower from 7/19/15 to 7/28/15. She stated she was always assigned to the hall where Resident #3 resided on second shift and she did rounds every two (2) hours to ensure resident care was completed. Further interview revealed she had not been notified of Resident #3 refusing showers. LPN #7 stated she did not review documentation, such as, the Documentation Survey Report to ensure showers had been completed.

Interview with the Director of Nursing (DON) on 07/30/15 at 12:40 PM, revealed she was unaware Resident #3's showers were not being given; however, they should have been. Per interview, the facility was in the process of possibly having a shower aide who would only do showers. The DON revealed nurses were responsible for ensuring all residents' care plan interventions were followed. She stated the nurses had access to residents' Comprehensive Care Plans in the computer and the CNA's had access to the Care Guide posted inside each residents' closet door. The DON stated nurses should be checking each resident's Care Guide to ensure the CNA's were following the resident's care through during

F 241 provided per the resident's primary aide. A very limited number of residents requested daily showers/baths, those will be provided by the primary aide on Sundays in accordance with the residents' request. The shower aides will be responsible for ensuring that all residents receive their shower per the schedule and for the documentation of care provided. Residents who choose to decline taking their shower or bath per schedule will be reported to their nurse who will then approach the resident to offer care and document offer and outcome. Residents who consistently refuse care (7 day period) will be referred to Social Services for an interview to determine reason for refusal and if concerns cannot be fully addressed by Social Services, a Family meeting will be held with the resident and responsible party for resolution of the concern.

Admin Nurse Team, including the DON, ADON, QI Nurse, MDS Nurses and Staff Facilitator will audit the Bathing Plan daily, Monday through Friday, to ensure all showers were provided according to the schedule and any that were not have the appropriate notification and documentation. Any concerns identified during the audit will be addressed & corrected as indicated.

The results of the audits will be reported to the DON upon completion and at the weekly

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 241 Continued From page 3
rounds. She stated the facility had formed a team for person centered care related to bathing and the team met every two (2) weeks. Per interview, the facility's administrative staff, which included the Administrator, the Quality Improvement (QI) Nurse, the Assistant Director of Nursing (ADON), Treatment Nurse, MDS Coordinators, and Staff Development Nurse, were to do rounds three (3) to four (4) times a day to ensure residents were receiving the care necessary. Continued interview revealed the administrative staff had certain hallways on which to perform the rounds, and they used a rounding audit sheet which they used weekly as a Quality Improvement (QI) tool. The DON stated the administrative staff was to look at the scheduled residents showers daily and ensure they were completed. Further interview revealed however, the administrative staff was not routinely checking the documentation of showers on the Documentation Survey Report in the facility's computerized system.

Interview, on 07/30/15 at 1:22 PM, with the Administrator revealed she was aware there was a problem with residents receiving their baths and the facility had been working on a plan to ensure residents received their baths as scheduled. She stated the facility was in the process of possibly scheduling shower aides who would be responsible for providing the showers and documenting them in the computerized system. Further interview revealed the bathing plan was ready, but had not been implemented because they had not inserviced staff yet.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=E

The services provided or arranged by the facility

F 241 QI meeting for four (4) weeks then monthly x 3. The results of these monthly review will be reported to the quarterly Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting. The Executive QI Committee will make recommendations for further action based upon the data presented.

F282 SRNA #1 was educated by the SDC Nurse on 8/6/2015 regarding following the care plan and providing incontinence care in a timely manner. SRNA #1, through 8/31/2015, will have unannounced audits of care practices by licensed nurses to determine if she continues to follow proper procedure and the care plan in providing care. Any concerns will be addressed immediately.

All SRNAs involved in failing to transfer Resident #2, as per the care plan, on 4/25/2015 were educated by RN #4 on that date regarding making sure they followed residents' care plan/guide.

Interviews by the DON on 8/20/2015 with care staff, including licensed nurses

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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.282 Continued From page 4
must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review it was determined the facility failed to provide service in accordance with each residents plan of care for three (3) of four (4) sampled residents (Residents #1, #2 and #4).

Resident #1's care plan was not followed related to provision of incontinence care. On 07/28/15, Resident #1 received incontinence care at approximately 7:15 AM, prior to leaving the facility for an appointment. Resident #1 returned to the facility at 10:45 AM; however, incontinence care was not performed again until 2:05 PM, after the resident's daughter asked staff to assist the resident to bed.

Resident #2's care plan was not followed related to transferring the resident with a gait belt and shoes.

Resident #4's care plan was not followed related to provision of assistance with toileting.

The findings include:
Interview with the Administrator on 7/30/15 at 1:22 PM revealed the facility did not have a policy related to ensuring staff followed residents' Comprehensive Care Plan interventions. However, the Administrator stated it was the responsibility of all staff to ensure each resident's care plan interventions were followed.

F.282 and SRNAs, and Resident #4 revealed that Resident #4 was independent with rolling walker for mobility, transfers and toileting. Care plan was updated 8/20/2015 to reflect the change in the resident's independence.

All residents have the potential to be affected by the failure of staff to provide care according to the written plan of care. To identify other residents, rounds to resident rooms to observe care being provided were completed by the Administrator 08/18/2015 through 08/21/2015 to audit for care being provided by staff in accordance with the resident's plan of care. No other residents were identified as being affected.

All staff who provide care to residents including licensed nurses, nursing assistants, activities staff, social services and dietary were educated by the Staff Facilitator, QI Nurse and/or DON 8/25/2015 8/6/2015 – 8/24/2015 regarding referring to the plan of care prior to providing care to any resident. Care guides are located inside each resident's closet door for quick easy reference of information contained in the care plan. Agency staff and new employees will receive this education as a part of orientation.

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 282 | Continued From page 5

1. Review of Resident #1's medical record revealed the facility re-admitted the resident on 06/10/15, with diagnoses which included Closed Fracture of the Right Femur and Dementia. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 06/16/15, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of a three (3) out of fifteen (15), indicating severe cognitive impairment. Further review of the MDS revealed the facility assessed Resident #1 as frequently incontinent of bowel and bladder and to require extensive assist of two (2) for toileting.

Review of Resident #1's Comprehensive Care Plan dated 06/24/15, revealed the facility had care planned the resident for a problem of Urinary Incontinence related to a Non Displaced Right Femur Fracture with a goal stating the resident would be free of skin breakdown. Continued review of the care plan revealed the interventions included: a bedside commode; encouraging fluid intake; and perineal care after each incontinent episode.

Observation of Resident #1 on 07/28/15 at 12:30 PM, revealed the resident was in Physical Therapy exercising her/his arms.

Interview with Resident #1's daughter on 07/28/15 at 2:00 PM, revealed Resident #1 had returned from an appointment at 10:45 AM, and had been sitting in the wheelchair ever since returning to the facility. Continued interview revealed staff had not offered and she had not asked staff to change Resident #1 yet.

Observation revealed during the interview with Resident #1's daughter, she (the daughter) rang

F 282 | To monitor the effectiveness of this education and ensure continued compliance with providing care in accordance with the written plan of care, the Administrative Nursing Team, including the Director of Nurses, Assistant Director of Nurses, QI Nurse, MDS Nurses and Staff Facilitator will monitor that resident care is being provided in accordance with the care plan and care guide as a part of their daily rounds, Monday through Friday. The results of these rounds will be documented on the Daily Rounds QI tool. Any concerns identified during these rounds will be addressed and corrected as indicated. The results of these rounds will be reported at the weekly QI meeting for four (4) weeks; then monthly x 3. The results of these weekly/monthly QI meeting will be reported to the quarterly Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive QI Committee. The Executive QI Committee will make recommendations for further action based upon the data presented.

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 282 | Continued From page 6

the resident's call bell and at 2:05 PM Certified Nursing Assistant (CNA) #1 and another CNA assisted the resident to bed. Further observation revealed Resident #1's adult pull up brief was wet and CNA #1 performed perineal/incontinence care for the resident, approximately three (3) hours and twenty (20) minutes after returning from the appointment.

Interview, on 07/28/15 at 2:15 PM, with CNA #1, who was assigned to Resident #1, revealed she had last changed the resident at 7:15 AM, when getting the resident ready for an appointment. She stated she knew Resident #1 was back from the appointment hours ago because the resident had eaten lunch after returning. Continued interview revealed incontinence care was to be performed every two (2) hours, but she had eight (8) residents assigned to her that day, and also had to give another resident a shower during the shift. CNA #1 stated she got behind on her work, but failed to report it to the nurse and failed to ask for help. She stated at times she would change residents when getting them up in the mornings and then not change them again until after lunch at 1:00 PM or 2:00 PM, because it was a busy hall and it took a lot of time feeding residents.

Even though Resident #1's care plan intervention was for perineal care to be provided after each incontinent episode, staff had not checked the resident after return from the appointment to provide the incontinent care, as per the care plan.

Interview, on 07/28/15 at 2:30 PM AM, with Licensed Practical Nurse (LPN) #1 who was assigned to Resident #1, revealed the residents were to receive incontinence care/toileting every two (2) hours. She stated however, at times the

F 282

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 282 | Continued From page 7

CNA's would report to the nurses they were behind or could not get their work done and the CNA's would miss their own lunch breaks in an attempt to get caught up. Per interview, she had spoken to the Director of Nursing (DON) about how busy the unit was and how difficult it was for the CNA's to get the work done a few weeks ago. Continued interview revealed as a nurse she did rounds checking on the residents in the morning and at the end of the shift, as well as, during medication pass. LPN #1 reported she was unaware of residents going longer than two (2) and a half hours without receiving incontinence care. According to LPN #1, Resident #1 should have been changed as soon as he/she returned from the appointment that day, and she was unaware the resident had not been changed until 2:05 PM.

Interview with the DON on 07/30/15 at 12:40 PM, revealed incontinence care was to be performed at least every two (2) hours or as per the scheduled toileting plan. She stated if a resident was out of the facility for an appointment, they should receive incontinence care as soon as they returned from the appointment. The DON stated incontinence care should be provided as soon as possible after return, because going too long without incontinence care could lead to skin breakdown, as well as, Urinary Tract Infections (UTI's). Continued interview revealed the nurses on the units should be ensuring incontinence care was provided by talking to the CNA's and checking residents to ensure they were not wet. Per interview, the facility was in the process of possibly having a shower aide who would only do showers which would free up CNA's to provide care more timely. Further interview revealed all nurses were responsible for ensuring all

F 282

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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)

F 282 Continued From page 8

residents' care plan interventions were followed. She stated the nurses had access to residents' Comprehensive Care Plans in the computer and the CNA's had access to the Care Guide posted inside each residents' closet door. The DON stated nurses should be checking each resident's Care Guide to ensure the CNA's were following the resident's care through during rounds.

2. Review of Resident #2's medical record revealed diagnoses which included Non Alzheimer's Disease, Urinary Retention and Chronic Kidney Disease. Review of the Quarterly MDS Assessments dated 02/02/15 and 05/04/15, revealed on both Assessments the facility assessed Resident #2 as having a BIMS score of thirteen (13) out of fifteen (15), indicating the resident was cognitively intact, and to require extensive assist of two (2) staff for transfers.

Review of Resident #2's Comprehensive Care Plan initiated 12/24/12, revealed the facility had care planned the resident for "actual" falls related to a history of falls with injury with multiple risk factors noted for falls including an unsteady gait, mental disorder and antidepressants and cardiovascular medications. Continued review of the falls care plan revealed the goal stated Resident #2 would be free from serious injury due to falls with interventions which included non-skid footwear. Continued review of Resident #2's Comprehensive Plan of Care revealed a care plan initiated 08/09/13, for the resident requiring assistance/potential to restore or maintain function of self-sufficiency for transferring from one (1) position to another related to decreased mobility and muscle weakness. Continued review of the self-sufficiency for transferring care plan revealed the goal stated Resident #2 would

F 282

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 282 Continued From page 9

F 282

receive the necessary physical assistance for transfer and the interventions included two (2) person assist with a gait belt for transfers.

Continued record review revealed a Progress Note dated 04/25/15 at 11:52 PM, written by Registered Nurse (RN) #4, which noted two (2) CNA's were in Resident #2's room and sat the resident on the side of the bed with his/her feet dangling. The Note revealed after sitting Resident #2 on the side of the bed, the two (2) CNA's attempted to transfer the resident to the wheelchair. The Note stated Resident #2's legs were weak and during the transfer attempt he/she was unable to transfer and was assisted back to bed where the resident laid down diagonally across the bed with her/his feet hanging over the bed. Per the Note, another CNA walked in the room, read Resident #2's care plan, placed shoes on the resident and a gait belt around the resident. Another attempt was made to transfer Resident #2 from the bed to the wheelchair; however, as they raised the resident to a sitting position, he/she began to slide off the bed. Continued review of the Note revealed the three (3) CNA's then lowered Resident #2 to the floor, and the resident was assisted off the floor with a Viking Lift (mechanical lift) with the assist of two (2) staff. The Notes revealed the CNA reported Resident #2 sliding to the floor to the nurse who assessed the resident with no injuries found, and he/she denied pain. Further review revealed a fall huddle was called and staff were educated related to fall precautions and residents' Care Guides (Nurse Aide Care Plan).

Review of the facility's "Investigation" document, dated 04/25/15, revealed Resident #2 was being transferred by staff from the bed to the chair on

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 282 Continued From page 10

F 282:

04/25/15, when the resident had to be lowered to the floor per staff. Continued review revealed Resident #2 was attempting transfer with two (2) staff, but was not participating in transfer and had to sit back down on the bed. The Investigation document revealed during the transfer, Resident #2 had on plain socks and staff was not using a gait belt to assist the resident with the transfer (as per the care plan). Per the Investigation document, another CNA arrived to help and placed a gait belt and socks and shoes on Resident #2. Another transfer was attempted with three (3) CNA's; however, the resident was unable to complete the transfer and started sliding off the bed and was lowered to the floor by the CNA's. Review revealed after being lowered to the floor, Resident #2 was assessed to have no injury noted and had to be assisted off floor with the Viking Lift. Continued review revealed education was completed with staff at the time of the incident regarding following residents' Care Guides/care plans and what to do if they see another member transferring a resident incorrectly.

Interview, on 07/30/15 at 10:00 AM, with Nurse Aide in Training (NAT) #1, revealed on 04/25/15 she was asked by Agency CNA #13 to assist with transferring Resident #2 from the bed to the wheelchair to take the resident to the shower room. She stated she was aware Resident #2's Care Guide was inside the resident's closet door; however, she did not check the guide for Resident #2's transfer requirements. Per interview, she was aware Resident #2 was to have shoes and a gait belt for transfer, but she and Agency CNA #13 tried to transfer Resident #2 without shoes and a gait belt. NAT #1 stated Resident #2 started to slide and they assisted the

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 282 Continued From page 11

resident to sit on the bed. Continued interview revealed she went to get Agency CNA #5 who put shoes and a gait belt on Resident #2 while the resident was lying sideways on the bed. NAT #1 stated she, Agency CNA #13 and Agency CNA #5 then attempted to transfer Resident #2 again, but they had to lower the resident to the floor. She stated no one went to inform the nurse Resident #2 was on the floor though, and CNA #12 came in and the four (4) CNA's transferred Resident #2 from the floor to the wheelchair. Per interview, Agency CNA #13 then transported Resident #2 to the general bathroom where NAT #1 and Agency CNA #13 transferred the resident from the wheelchair to the whirlpool bath with the Viking Lift.

Phone interview was to be attempted with Agency CNA #13; however, the Surveyor was unable to reach Agency CNA #13, as the agency was unable to find his/her phone number.

Interview with Agency CNA #5 on 07/30/15 at 9:30 AM, revealed, on the day of the incident involving Resident #2, she noticed a call bell going off and stopped to check on Resident #2. She stated two (2) CNA's were in the room with Resident #2 and the resident was lying sideways across the bed, at the end of the bed. Per interview, she checked Resident #2's Care Guide, which was inside the resident's closet door, and noted the resident was to have shoes or non skid socks and a gait belt for transfer. Agency CNA #5 stated however, Resident #2 did not have shoes or nonskid socks or a gait belt on. Continued interview revealed the CNA's put the gait belt and shoes on Resident #2 and attempted to raise the resident to a sitting position and had to lie him/her back down on the bed. Agency

F 282

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 282	<p>Continued From page 12</p> <p>CNA #5 stated the four (4) CNA's, including herself, tried to stand Resident #2, but had to ease the resident to the floor. She stated she went and got the Viking mechanical lift and the CNA's then assisted Resident #2 to the wheelchair, and the resident was taken to the whirlpool bath.</p> <p>Interview with RN #4 on 07/30/15 at 2:20 PM, revealed NAT #1 and the CNA's involved in the incident did not notify her Resident #2 was on the floor at the time of the fall. Per interview, she was not notified in order to assess Resident #2 until the resident was already in the whirlpool bath. She stated Resident #2 had sustained no injuries and she immediately inserviced all staff involved in the incident on ensuring they got the nurse immediately if a resident had an accident and on making sure they followed residents' care plans.</p> <p>Interview with the Quality Assurance (QA) Nurse on 07/29/15 at 3:00 PM, revealed Resident #2 had muscle weakness and was receiving Physical Therapy at the time due to a previous fall. Per interview, she had reviewed the incident involving Resident #2, and determined the two (2) staff initially assisting Resident #2 to transfer did not follow the resident's care plan related to using a gait belt and ensuring he/she had shoes on, but should have.</p> <p>Interview with the DON on 07/30/15 at 12:40 PM, revealed the CNA's caring for Resident #2 at the time of the incident, should have ensured they had the shoes and gait belt on the resident prior to the transfer, as per his/her Care Plan. She stated the CNA's Care Guides were kept inside the residents' closet doors for review prior to providing care.</p>	F 282		
-------	---	-------	--	--

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 282 Continued From page 13

F 282.

3. Review of Resident #4's Medical Record revealed the facility re-admitted the resident on 04/02/15, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Cerebral Vascular Accident (CVA) and weakness. Review of the Quarterly MDS dated 07/07/15, revealed the facility assessed Resident #4 as having a BIMS score of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed Resident #4 as requiring extensive assist of one (1) person for transfers, ambulation and toileting.

Review of Resident #4's Comprehensive Care Plan dated 04/03/15, revealed the facility care planned the resident to require assistance for the physical process of toileting related to impaired mobility. Continued review revealed the goal stated Resident #4 would ask for and receive the necessary assistance. Further review revealed the interventions included Resident #4 required one (1) person constant supervision and physical assist for safety, for adjusting clothing, for washing hands and for perineal care. Continued review of the Comprehensive Care Plan revealed the facility care planned Resident #4 to also require assistance for transfers from one (1) position to another related to unsteady gait with a goal stating the resident would receive the necessary physical assistance for transfers. Review of the care plan revealed interventions which included Resident #4 was to have one (1) person assist for constant guidance and physical assist with a gait belt for transfers.

Review of Resident #4's CNA Care Guide revealed the resident required: one (1) person assist with a gait belt for ambulation; one (1)

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 282 Continued From page 14
person constant guidance and physical assist with a gait belt for transfers; and staff to provide adult briefs and wipes for occasional incontinence of bladder.

F 282

Observation, on 07/28/15 at 12:45 PM, revealed Resident #4 stood up and ambulated with a walker to the closet to get an adult brief, then ambulated to the bathroom and transferred on his/her own to the toilet without staff's supervision or assistance. Continued observation revealed Resident #4 transferred without assistance of staff from the toilet and stood at the walker, cleansed himself/herself and put on the new adult brief without staff's supervision or assistance. Further observation revealed Resident #4 then ambulated with the walker without staff's supervision or assistance out of the bathroom and into his/her room and sat down in a chair. Interview with Resident #4, immediately after the observation, revealed the resident usually transferred, toileted and ambulated independently without staff's supervision or assistance. Even though Resident #4's Comprehensive Care Plan had interventions which included one (1) person constant supervision and physical assist for safety, for adjusting clothing, for washing hands and for perineal care with the use of a gait belt.

Interview, on 07/29/15 at 1:45 PM, with CNA #11, who was assigned to Resident #4 revealed she had looked at the Care Guide kept inside the resident's closet door for the care he/she required. However, she stated Resident #4 was independent with ambulation, transfers and toileting. Review of Resident #4's Comprehensive Care Plan revealed however, the resident's interventions included one (1) person constant supervision and physical assist for

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 282 Continued From page 15
safety, for adjusting clothing, for washing hands and for perineal care with the use of a gait belt.

Interview with RN #1 on 7/29/15 at 1:45 PM, revealed she was assigned to Resident #4. Per interview, the CNA's were to refer to the residents' Care Guides located inside the resident's closet door to see what type of care residents required. She stated she did a walk through each shift to ensure the care was given for residents, as per their care plans; however, stated she was unaware Resident #4 was toileting independently instead of as per his/her care plan.

Further interview with the DON on 07/30/15 at 12:40 PM, revealed all nurses were responsible for ensuring all residents' care plan interventions were followed. She stated the nurses had access to residents' Comprehensive Care Plans in the computer and the CNA's had access to the residents' Care Guides posted inside each resident's closet door. The DON stated nurses should be checking each resident's Care Guide to ensure the CNA's were following the resident's care through during rounds.

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D 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

F 282

F315
SRNA #1 was educated by the SDC Nurse on 8/6/2015 regarding following the care plan and providing incontinence care in a timely manner. SRNA #1, through 8/31/2015, will have unannounced audits of care practices by licensed nurses to determine if she continues to follow proper incontinence care procedures. Any concerns will be addressed immediately.

F 315
All residents incontinent of bladder have the potential to be affected by the failure of staff to provide incontinence care as needed. All incontinent residents were

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 315 | Continued From page 16
function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services for one (1) of four (4) sampled residents (Resident #1).

Resident #1 received incontinence care at approximately 7:15 AM, and left the facility for an appointment. Resident #1 returned to the facility at 10:45 AM; however, incontinence care was not provided for the resident again until 2:05 PM, after the resident's daughter asked staff to assist the resident to bed.

The findings include:

Review of the facility's, "Incontinence Care Policy", undated, revealed perineal care would be given after each incontinent episode.

Review of Resident #1's medical record revealed the facility re-admitted the resident on 06/10/15, with diagnoses of Dementia and a Closed Fracture of the Right Femur. Review of Resident #1's Significant Change Minimum Data Set (MDS) dated 06/16/15, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), which indicated he/she was severely cognitively impaired. Further review of the MDS revealed the facility assessed Resident #1 to be frequently incontinent of bowel and bladder and to require extensive assistance of two (2) for

F 315 | observed by the Administrator 8/18/2015 through 8/21/2015 to audit for incontinence care being provided by staff as needed and in accordance with the resident's plan of care. No other residents were identified as being affected.

All Nursing staff were educated by the Staff Facilitator, QI Nurse and/or DON 8/6/2015 – 8/23/2015 regarding the timely and appropriate provision of incontinence care to any resident. Agency staff and new employees will receive this education as a part of orientation.

To monitor the effectiveness of this education and ensure continued compliance with providing timely and appropriate provision of incontinence care to any resident, to prevent any infections to the extent possible and care in accordance with the written plan of care, the Administrative Nursing Team, including the Director of Nurses, Assistant Director of Nurses, QI Nurse, MDS Nurses and Staff Facilitator will monitor that resident care is being provided in accordance with the care plan and care guide as a part of their daily rounds, Monday through Friday. The results of these rounds will be

8/25/2015

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 315 : Continued From page 17
toileting.

Review of Resident #1's Comprehensive Care Plan dated 06/24/15, revealed the resident had a care plan for a problem of Urinary Incontinence related to a Non Displaced Right Femur Fracture with a goal stating the resident would be free of skin breakdown. Continued review of the care plan revealed interventions which included providing perineal care after each incontinent episode.

Observation of Resident #1 on 07/28/15 at 12:30 PM, revealed the resident was in Physical Therapy exercising his/her arms.

Interview with Resident #1's daughter on 07/28/15 at 2:00 PM, revealed the resident had gone out for an appointment and returned at 10:45 AM. Per interview, Resident #1 had been sitting up in the wheelchair since returning and she had not asked staff to change the resident yet. Resident #1's daughter rang the call light during the interview, and at 2:05 PM, Certified Nursing Assistant #1 and another CNA assisted the resident to bed. Observation at that time revealed after transferring Resident #1 to bed, the CNA's removed the resident adult pull up brief which was wet, then CNA #1 provided perineal/incontinence care for him/her.

Interview, on 07/28/15 at 2:15 PM, with CNA #1, who was assigned to Resident #1's care, revealed revealed incontinence care was to be performed every two (2) hours, but she was assigned to eight (8) residents care that day and had a resident's shower also to give during her shift. She stated she had last changed and provided incontinence care for Resident #1 at

F 315 : documented on the Daily Rounds QI tool. Any concerns identified during these rounds will be addressed and corrected as indicated.

The results of these rounds will be reported at the weekly QI meeting for four (4) weeks; then monthly x 3. The results of these weekly/monthly QI meeting will be reported to the quarterly Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive QI Committee. The Executive QI Committee will make recommendations for further action based upon the data presented.

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	Continued From page 18 7:15 AM, when she was preparing the resident to leave for his/her appointment. Per interview, she knew Resident #1 had returned from the appointment as the resident ate lunch. Continued interview she had gotten behind on her work that day which she had failed to report to the nurse and failed to ask for help. CNA #1 stated there were times she would change residents when getting them up in the mornings, and then be unable to change them again until after lunch at 1:00 PM or 2:00 PM. Further interview this was due to the hall she was assigned to being very busy and a lot of her time was taken up with feeding residents their meals. Interview, on 07/28/15 at 2:30 PM, with Licensed Practical Nurse (LPN) #1 who was assigned to Resident #1, revealed residents were to be provided incontinence care or toileting every two (2) hours. LPN #1 stated however, sometimes the CNA's would come to the nurses and tell them they were behind with resident care and would miss their own lunch break to try to get caught up. According to LPN #1, she had talked to the Director of Nursing (DON) a few week ago about how difficult it was for the CNA's to get their work done and how busy the unit was. She stated as a nurse she did rounds on the residents to check on them in the morning, at the end of her shift and during her medication pass. Further interview revealed however, she was not aware of any residents going longer than two (2) and a half hours without having incontinence care provided. LPN #1 stated Resident #1 should have received incontinence care and been changed as soon as the resident returned from the appointment. She stated she was unaware Resident #1 had not been changed until 2:05 PM, but should have been.	F 315			

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 315 Continued From page 19

Interview with the DON on 07/30/15 at 12:40 PM, revealed incontinence care was to be done at least every two (2) hours or as per the scheduled toileting plan. The DON stated when residents went out for appointment, they should have incontinence care provided as soon as they returned because going too long without incontinence care could lead to skin breakdown, as well as, possible Urinary Tract Infections (UTI's). She stated the nurses on the units should be ensuring this was done by talking to the CNA's and checking residents to ensure they were not wet. Further interview revealed the facility was in the process of possibly having a shower aide who would only do showers. She stated if the facility did that it would free up the other CNA's to be able to provide more timely care.

Interview with the Administrator on 07/30/15 at 1:22 PM, revealed Resident #1 should have received incontinence care as soon as the resident arrived back at the facility from the appointment.

F 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced

F 315

F323

The bottles of insulin and syringes were secured inside the medication cart by RN #1 upon her interview by the Surveyor. RN #1 was counseled by the Administrator on 8/13/2015 regarding leaving her medication cart unattended with medications and sharps unsecured on its top.

F 323: All SRNAs involved in failing to notify the nurse regarding the fall of Resident #2, on 4/24/15, during transfer were educated by RN #4 on that date regarding making sure they reported any fall immediately to licensed staff for assessment before moving the resident.

All residents have the potential to fall. A visual round was conducted by the DON.

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 Continued From page 20
by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as was possible, and each resident received adequate supervision and assistance devices to prevent accidents for one (1) of four (4) sampled residents (Resident #2) and two (2) unsampled residents (Unsampled Residents A and B).

Observation revealed ten (10) vials of insulin medication and two (2) Insulin syringes on top of an unattended medication cart.

In addition, Resident #2 was lowered to the bed and then to the floor after an inappropriate transfer.

The findings include:

1. Review of the facility's policy titled, "Medication Storage", undated, revealed medications were to be stored in the medication cart. Per the Policy, the medication cart should be locked at all times when not under the direct physical supervision of a licensed nurse.

Observation, on 07/28/15 at 9:42 AM, revealed a medication cart in hallway unattended by staff. Continued observation revealed stored on top of the medication cart was a box containing ten (10) vials which included the following: one (1) vial of Humulin R insulin; three (3) vials of Novolog insulin; two (2) vials of Humulin insulin; and four (4) vials of Lantus insulin. In addition, observation revealed there was two (2) insulin syringes in their wrapper stored on top of the

F 323 Maintenance Director & Environmental Services on 8/18/2015-8/20/2015 to identify any other hazards or risks in the residents' environment. Interventions were implemented to reduce any hazards or risks identified.

All nursing staff were educated by the Staff Facilitator, QI Nurse and/or DON through mandatory in-services held 8/6/2015 – 8/23/2015 regarding the absolute need for an assessment by licensed nurse of any resident who has fallen prior to being moved. In addition, all licensed nurses and KY Medication Aides were in-serviced regarding to completely secure all sharps and medications before leaving the medication/treatment cart unattended.

To monitor the effectiveness of this education and ensure continued compliance with secured medication/ sharps, the Administrative Nursing Team, including the Director of Nurses, Assistant Director of Nurses, QI Nurse, MDS Nurses and Staff Facilitator will monitor medication carts during their daily rounds, Monday through Friday. The results of these rounds will be documented on the Daily Rounds QI tool. Any concerns identified during these rounds will be addressed and corrected as indicated.

8/25/2015

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 Continued From page 21
medication cart. Further observation revealed the nurse returned to the medication cart at 9:45 AM.

Interview with Registered Nurse (RN) #1 on 07/27/15 at 9:45 AM, at time the nurse returned to the medication cart, revealed she did not think there was enough room in the medication cart for her to store the insulin. Observation revealed RN #1 opened drawers on the medication cart and found space to store the insulin inside where it could be locked. Continued interview revealed RN #1 stated she should have ensured the insulin was stored in the locked medication cart when she left the cart unattended. RN #1 stated Unsampld Resident A was a wanderer who often wandered the hallway where the medication cart was parked at the time of the Surveyor's observations, and Unsampld Resident B also wandered from the other side of the facility over to that hallway.

Interview with the Assistant Director of Nursing (ADON) on 07/28/15 at 1:10 PM, revealed medications should never be left stored out on top of the medication cart unattended because someone could gain access to them and take the medications. She stated she knew of just two (2) wanderers who were confused and would ambulate on that hall. Further interview revealed the two (2) residents indicated were Unsampld Resident A and Unsampld Resident B.

Interview with the Director of Nursing (DON) on 07/30/15 at 12:40 PM, revealed the medication carts should be locked with all medications locked inside when unattended, as per the facility's policy and for residents' protection.

2. Review of Resident #2's medical record

F 323 The results of these rounds will be reported at the weekly QI meeting for four (4) weeks; then monthly x3. The results of these weekly/monthly QI meeting will be reported to the quarterly Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive QI Committee. The Executive QI Committee will make recommendations for further action based upon the data presented.

The QI Nurse will monitor for appropriate reporting of falls and documentation of assessment of residents prior to moving of any resident who has fallen through her investigation and review of falls monthly x3. Any concerns identified during this review will be addressed at the time and included with her monthly report to the QI Committee.

The results of these monthly meetings will be reported to the quarterly Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 Continued From page 22

revealed diagnoses which included Non Alzheimer's Disease, Urinary Retention, and Chronic Kidney Disease. Review of Resident #2 Quarterly Minimum Data Set (MDS) Assessments dated 05/04/15 and 02/02/15, revealed on both Assessments the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated no cognitive impairment, and to require extensive assist of two (2) for transfers.

Review of the Comprehensive Care Plan initiated 12/24/12, for Resident #2 revealed the resident had a history of falls with injury and had multiple risk factors for falls including an unsteady gait, antidepressants and cardiovascular medications and mental disorder. Per the care plan the goal stated Resident #2 would be free of serious injury from falls with interventions which included nonskid footwear. Continued review of the Comprehensive Care Plan initiated 08/09/13, revealed Resident #2 required assistance for transferring from one (1) position to another related to decreased mobility and muscle weakness with a goal noting the resident would receive the necessary physical assistance to transfer. Further review of the care plan revealed the interventions include a two (2) person assist with gait belt for transfers.

Continued record review revealed a Progress Note dated 04/25/15 at 11:52 PM, written by Registered Nurse (RN) #4, which noted two (2) Certified Nursing Assistants (CNA's) were in Resident #2's room attempting to transfer the resident and sat him/her up on the side of the bed with his/her feet dangling. According to RN #4's Note, the two (2) CNA's attempted to assist Resident #2 to stand and transfer to the

F 323 pertinent to the reports being discussed at the Executive Committee meeting. The Executive QI Committee will make recommendations for further action based upon the data presented.

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 Continued From page 23

wheelchair; however, the resident's legs were weak and he/she was unable to complete the transfer and the CNA's assisted him/her back to bed. Continued review of the Note revealed Resident #2 laid down on the bed diagonally with the resident's feet hanging over the edge of the bed. The Note revealed another CNA came to Resident #2's room, read the resident's care plan, and put a gait belt around the resident and shoes on him/her. Review of the Note revealed the CNA's attempted to transfer Resident #2 again, but as they assisted the resident to a sitting position, he/she started to slide off the bed. According to the Note, as Resident #2 was sliding off the bed the CNA's lowered the resident to the floor with his/her back against the bed. The Note stated the CNA's assisted Resident #2 off the floor with the use of a Viking Lift (mechanical lift) with the assist of two (2) staff. Further review revealed the CNA then reported the resident sliding to the floor to the nurse. The nurse assessed Resident #2 with no injuries found and the resident denied pain. Further review of the Note revealed a fall huddle was called and staff were educated about fall precautions and residents' Care Guides (Nurse Aide Care Plan).

Review of the facility's "Investigation" document, dated 04/25/15, revealed Resident #2 was being transferred per staff from the bed to the chair on 04/25/15, when the resident had to be lowered to the floor by staff. The Investigation document revealed Resident #2 was attempting to transfer with two (2) staff, but was not participating in transfer, and had to sit back down on the bed. Per the Investigation document, at the time of the transfer attempt, Resident #2 had on plain socks and staff was not using a gait belt to assist the resident with the transfer. Continued review

F 323

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 Continued From page 24

F 323

revealed another CNA arrived to help and placed a gait belt and socks and shoes on Resident #2. The Investigation document revealed a transfer was attempted again with the three (3) CNA's assisting; however, Resident #2 was unable to complete the transfer, started to slide off the bed and was lowered to the floor. Further review revealed Resident #2 was assisted off the floor with a Viking Lift, and had no injury, with education completed for staff at the time of the incident in reference to following residents' Care Guides and what to do if they see another member transferring a resident incorrectly. In addition, review of the investigation document revealed RN #4's written witness statement which noted the CNA's reported Resident #2 had slid off the bed and was lowered to the floor when they were trying to transfer the resident. RN #4's written statement revealed Resident #2 was in the bath tub when she was notified, and after the resident was transferred back to bed she assessed him/her with no injuries noted. Further review of RN #4's written statement revealed a fall huddle was called to determine what happened.

Interview, on 07/30/15 at 10:00 AM, with Nurse Aide in Training (NAT) #1, revealed on 04/25/15 she was asked by Agency CNA #13 to assist with transferring Resident #2 from the bed to the wheelchair in order to take the resident to the shower room. She stated she was aware Resident #2's Care Guide was posted in the resident's closet, but she did not check the Guide. According to NAT #1 she was aware Resident #2 was to have shoes and a gait belt when being transferred; however, she and Agency CNA #13 still attempted to transfer the resident without shoes and a gait belt. Per interview, Resident

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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)

F 323 Continued From page 25

#2's feet started to slide and so they assisted the resident to sit back down on the bed. She stated she went to get Agency CNA #5 who put shoes and a gait belt on Resident #2 while the resident was lying sideways on the bed. Continued interview revealed the three (3) CNA's attempted to transfer Resident #2 again, but they had to lower the resident to the floor. According to NAT #1, no one went to get the nurse when the resident was lying on the floor. She stated CNA #12 came in Resident #2's room also, and the four (4) CNA's transferred the resident from the floor to the wheelchair. Per NAT #1, Agency CNA #13 then transported Resident #2 to the facility's general bathroom where NAT #1 and Agency CNA #13 transferred the resident from the wheelchair to the whirlpool with the Viking Lift. Further interview revealed she should have informed the nurse they were having difficulty transferring Resident #2, and also should have notified the nurse when the resident was lowered to the floor, so the nurse could assess the resident.

The Surveyor was unable to phone Agency CNA #13, as the agency was unable to find a phone number for the CNA.

Interview with Agency CNA #5 on 07/30/15 at 9:30 AM, revealed on the day of the incident involving Resident #2 she had noticed the call light going off and stopped to check on the resident. Per interview, two (2) CNA's were in the room with Resident #2 who was lying sideways at the end of the bed. She stated she checked Resident #2's Care Guide which was inside the resident's closet door, and noted the resident was to have shoes or nonskid socks and a gait belt for transfers. Continued interview

F 323

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 | Continued From page 26

F 323

revealed the CNA's placed the gait belt and shoes on Resident #2 and attempted to assist the resident to a sitting position, but had to lay the resident back on the bed. She stated CNA #12 came in and got the stand up mechanical lift but they could not get the belt for the lift around Resident #2. According to Agency CNA #5, the four (4) CNA's tried to stand Resident #2 up, but had to ease the resident to the floor. Agency CNA #5 stated the CNA's did not notify the nurse Resident #2 was on the floor because the resident's legs were straight and there did not appear to be an injury. She stated she got the Viking mechanical lift and they assisted Resident #2 to the wheelchair. Further interview revealed Agency CNA#13 took Resident #2 straight to the whirlpool before the nurse assessed the resident. She further stated she and CNA #12 went straight to RN #4 and told her about the incident so she could assess Resident #2.

Interview with RN #4 on 07/30/15 at 2:20 PM, revealed NAT #1 and the CNA's involved in the incident did not notify her Resident #2 was on the floor at the time of the fall. She stated she was not notified in order to assess Resident #2 until the resident was already in the whirlpool bath. Per interview, Resident #2 sustained no injuries as a result of being lowered to the floor. Further interview revealed she had immediately inserviced all the staff involved in the incident regarding immediately getting the nurse to assess if a resident had an accident and to follow residents' care plans.

Interview with the Quality Assurance (QA) Nurse on 07/29/15 at 3:00 PM, revealed she had reviewed the incident and the two (2) staff initially assisting the resident to transfer did not follow the

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 Continued From page 27
care plan related to a gait belt and shoes and the resident had muscle weakness and was receiving physical therapy at the time due to a previous fall.

F 323

Interview with the Staff Development Nurse (SDN) on 07/30/15 at 12:00 PM, revealed the QA Nurse reviewed the incidents and would have her follow up with staff inservices as needed, and let her know whether the inservice needed to be for all facility staff, or all nursing staff or most of the nursing staff. She stated after the incident involving Resident #2 she did an inservice; however, that inservice was not mandatory and therefore, not all nursing staff was inserviced. Further interview revealed she had inservices on payday as she could inservice staff on all shifts. She stated however, agency staff did not necessarily get the same inservices as facility staff.

Interview with the DON on 07/30/15 at 12:40 PM, revealed the CNA's should have ensured they had the shoes and gait belt on Resident #2, as per the resident's Care Guide, prior to attempting to transfer the resident. Per interview resident's Care Guides, were the Nurse Aide Care Plans, and were posted inside the residents' closet doors. Continued interview revealed Resident #2 should have been assessed immediately after the fall by the nurse due to possible injury. In addition, she stated the nurse should have also been notified of the difficulty in transferring Resident #2 prior to the fall.

F 441
SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441 Continued From page 28
safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

F441
SRNAs #1 and #6 were re-educated by the Staff Facilitator on 7/28/2015 regarding the procedure for perineal care including changing of gloves and washing of hands. This education involved a successful return demonstration by the SRNAs.

All incontinent residents have the potential to be affected by the failure of staff to follow procedures for incontinence care.

All SRNAs who provide care to incontinent residents, were in-serviced on proper incontinence care. All SRNAs were checked off by the SDC Nurse on a return demonstration of providing perineal care in accordance with Infection Control Policies and Practice 7/28/2015 - 8/23/2015.

To monitor the effectiveness of this education and ensure continued compliance with the Infection Control Program, the Administrative Nursing Team, including the Director of Nurses, Assistant Director of Nurses, QI Nurse, MDS Nurses and Staff Facilitator will monitor resident incontinence care is being provided in accordance with the Infection Control Program through daily rounds, Monday through Friday. Each Admin Nurse will observe one occasion of

8/25/2015

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441 Continued From page 29

Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection for two (2) of four (4) sampled residents (Resident #1 and #2).

Observation of perineal care for Resident #1 revealed staff cleansed the resident's buttocks while he/she was standing, then assisted the resident to lie down on the bed. The staff person then performed perineal care with the same soiled gloves used to cleanse Resident #1's buttocks. Further observation revealed after performing the perineal care, the staff person touched items in the resident's room with the soiled gloves.

Observation of perineal care for Resident #2 revealed staff performed perineal care by wiping the perineal area back to front.

The findings include:

Review of the facility's policy titled, "Handwashing Procedure", dated September 2014, revealed staff should wash their hands after handling contaminated items, such as, soiled incontinent briefs, linens or trash, and before and after contact with residents.

Review of the facility's policy titled, "Perineal Care", dated April 2013, revealed the objective included to prevent infection. The Policy revealed the perineal care procedure should be explained to the resident, and the perineal area then exposed and washed front to back.

F 441 perineal care per round each day for the next four weeks and then three (3) occasions of perineal care for the following two weeks followed by one occasion of perineal care the following two weeks. The results of these rounds will be documented on the Daily Rounds QI tool. Any concerns identified during these rounds will be addressed and corrected as indicated.

The results of these rounds will be reported at the weekly QI meeting for four (4) weeks; then monthly x 2. The results of these weekly/monthly QI meeting will be reported to the quarterly Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive QI Committee. The Executive QI Committee will make recommendations for further action based upon the data presented.

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441 | Continued From page 30

F 441

1. Review of Resident #1's medical record revealed diagnoses which included Alzheimer's Disease, and Closed Fracture of the Right Femur. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 06/016/15, revealed the facility assessed Resident #1 to be severely cognitively impaired, as frequently incontinent of bowel and bladder and to require extensive assistance of two (2) staff for toileting.

Observation, on 07/28/15 at 2:05 PM, of perineal care performed for Resident #1 by Certified Nursing Assistant (CNA) #1 revealed the CNA wiped Resident #1's buttocks with a wet wipe, then she and another CNA assisted the resident to lie down on the bed. Continued observation revealed CNA #1, with the same soiled gloves and new wipes, then provided perineal care for Resident #1. Further observation revealed CNA #1 then, with the same soiled gloves still in place, opened Resident #1's dresser drawer and placed the wipes in the drawer, without removing the soiled gloves and washing or sanitizing her hands. In addition, observation revealed CNA #1 then removed the glove from her right hand and used that hand on the bed control to lower the bed; however, did not wash or sanitize her hand prior to touching the bed control.

Interview with CNA #1 on 07/28/15 at 2:15 PM, revealed she did not realize she needed to wash or sanitize her hands after cleansing the buttocks and prior to performing perineal care. She stated however, she could see how that could cause cross contamination. Further interview revealed she should have removed her gloves and washed her hands after performing the perineal care and

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 31</p> <p>prior to touching items in the resident's room.</p> <p>2. Review of Resident #2's medical record revealed diagnoses which included Non Alzheimer's Disease, Urinary Retention and Chronic Kidney Disease. Review of the Quarterly MDS dated 05/04/15, revealed the facility assessed Resident #2 as cognitively intact, as occasionally incontinent of bowel and frequently incontinent of urine and to require extensive assistance of two (2) staff for toileting.</p> <p>Observation, on 07/28/15 at 12:30 PM, revealed Resident #2 was standing in the bathroom assisted by CNA #6 and another CNA. Continued observation revealed CNA #6 proceeded to perform perineal care by wiping Resident #2's perineal area from the perineum to the vaginal area.</p> <p>Interview with CNA #6 on 07/28/15 at 12:40 PM, revealed she should have wiped Resident #2's perineal area from front to back; however, it was difficult to perform the perineal care for the resident while he/she was standing. She stated she had been inserviced at the facility in the past and knew to wipe front to back when performing perineal care.</p> <p>Interview, on 07/30/15 at 12:40 PM, with the Director of Nursing (DON) revealed she was unaware of any routine auditing by the facility of staff performing perineal care to ensure it was being done correctly. The DON stated however, the facility had verbal inservices in the recent past related to perineal care. Per interview, perineal care should be done by wiping the perineal area front to back. Further interview revealed staff should wash their hand prior to performing</p>	F 441		
-------	--	-------	--	--

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

PRINTED: 08/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441 | Continued From page 32
perineal care and after the perineal care before touching other items in a resident's room. The DON revealed if staff did not do this, it was an infection control concern.

F 441