

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

PRINTED: 09/18/2013
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 09/06/2013
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 000	INITIAL COMMENTS A Standard Recertification Survey was initiated on 09/03/13 and concluded on 09/06/13 with no deficiencies cited.	F 000	

RECEIVED
SEP 27 2013
BY: _____

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.

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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311		
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{K 000}	INITIAL COMMENTS An on-site revisit was conducted on 09/30/13 and found the facility to be in compliance as alleged on 09/29/13.	{K 000}			

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

TITLE

(X6) DATE

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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
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70 (a) BUILDING: 01 PLAN APPROVAL: 1962. Renovated in 1994 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected SMOKE COMPARTMENTS: Five (5) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM Installed in 1991 and upgraded in 1994. FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) Installed in 1994 EMERGENCY POWER: Type II Diesel Generator installed in 1979. A Life Safety Code Survey was conducted on 09/04/13 with deficiencies cited. The facility is licensed for one hundred four (104) beds with a census of ninty five (95) the day of the survey. The highest Scope and Severity was at the "D" level.	K 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. 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.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066		

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SEP 27 2013
BY _____

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

TITLE

(X6) DATE

[Handwritten Signature]

Administrator

9/26/2013

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

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K 066	Continued From page 1 (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoking areas were equipped with a metal container with a self-closing cover according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments. The findings include: Observation, on 09/04/13 at 1:50 PM, revealed the resident smoking area did not contain a metal container with a self-closing cover. Smoking	K 066	A metal container with a self-closing cover device was obtained and placed in the resident smoking area on September 16, 2013. All residents have the potential to be affected. Smoking is prohibited within the Nursing Home with the exception of the resident smoking area found to be non-compliant. Metal containers with self-closing cover devices were obtained and placed in smoking areas outside the building as well on September 16, 2013. Environmental Services staff was in-services on September 16, 2013, with regard to the placement of the metal containers with self-closing cover devices in the smoking areas and emptying and cleaning the containers. The Administrator will observe for the placement of the metal containers with self-closing cover devices in smoking areas during daily rounds Monday through Friday. Results of these rounds will be reported monthly to the Safety Committee and included in the quarterly report by the Safety Committee to the Quality Improvement	9/29/13

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K 066	<p>Continued From page 2</p> <p>areas must contain a metal container with a self-closing cover to dump discarded cigarette butts into. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 09/04/13 at 1:50 PM, with the Maintenance Director revealed he was not aware the area needed a metal container with a self-closing cover. Further interview revealed the same for the staff smoking area.</p> <p>The findings were confirmed with the Administrator at the Exit Conference.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(2) Smoking by patients classified as not responsible shall be prohibited.</p> <p>Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.</p>	K 066	<p>Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, QI Nurse and any other persons required to provide information pertinent to the reports being presented and discussed at the Executive QI Committee meeting. The Executive QI Committee will make recommendations for further action such as more staff education, change in process, procedure or policy based upon data presented.</p>	

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K 066	Continued From page 3 (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. NFPA 101 LIFE SAFETY CODE STANDARD	K 066		
K 147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there was an adequate number of electrical receptacles to meet the needs of residents according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, one (1) resident, staff and visitors. The findings include: Observation, on 09/04/13 at 11:04 AM, revealed an oxygen deliver device was plugged into a multiple plug adapter. The observation was confirmed with the Maintenance Director. Medical equipment cannot be plugged into multiple plug adapters due to increased risk of electrical shock. Interview, on 09/04/2013 at 11:04 AM, with the	K 147	The oxygen device was unplugged from the multiple plug adapter and plugged into the wall receptacle on September 6, 2013. Additional wall receptacles were added to that resident room on September 12, 2013. All residents have the potential to be affected. The Administrator and Maintenance Manager inspected each resident room 9/23/13-9/25/2013 to observe for other medical devices plugged into multiple plug adapters. All inappropriate uses of multiple plug adapters were corrected when found and additional wall receptacles added as needed. All staff was in serviced by the Staff Facilitator September 25 – 28, 2013, that medical devices are to be plugged directly into a wall receptacle and can not be plugged into a multiple plug adapter. The Administrator will observe for medical devices to be plugged into wall receptacles during daily rounds Monday through Friday. Results of these rounds	9/29/13

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K 147	Continued From page 4 Maintenance Director revealed he was aware medical equipment should not be plugged into multiple plug adapters. The findings were confirmed with the Administrator at the time of the Exit Conference. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	will be reported monthly to the Safety Committee and included in the quarterly report by the Safety Committee to the Quality Improvement Executive Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, QI Nurse and any other persons required to provide information pertinent to the reports being presented and discussed at the Executive QI Committee meeting. The Executive QI Committee will make recommendations for further action such as more staff education, change in process, procedure or policy based upon data presented.	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	The ABHR (Soap) dispensers in resident rooms 155, 154, 153, and 134 were removed from the wall and hand pump dispensers placed on the sink counters in those rooms for resident use on September 20, 2013. The ABHR (Soap) dispensers in the lobby bathroom and the North employee bathroom were	

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K 211	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure Alcohol Based Hand Rub (ABHR) dispensers were mounted according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, twenty five (25) residents, staff and visitors. The findings include: Observation, on 09/04/13 at 10:45 AM, revealed an ABHR dispenser was mounted above an electrical receptacle in resident room 155. Further observations revealed the same for resident rooms 154, 153, 134, the lobby bathroom and the North employee bathroom. ABHR dispensers cannot be mounted above an ignition source due to increasing the risk of fire. The observations were confirmed with the Maintenance Director. Interview, on 09/04/13 at 10:45 AM, with the Maintenance Director revealed he had not identified the ABHR dispensers as being installed near an ignition source. The findings were confirmed with the Administrator during the exit conference. Reference: NFPA 101 (2000 edition) 19.3.2.7 Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide	K 211	relocated to another wall away from any ignition source such as electrical outlets. These were moved on September 20, 2013. All residents have the potential to be affected. The Administrator and Maintenance Manager inspected each resident room 9/23/13-9/25/2013 to observe for other soap dispensers located above or adjacent to an ignition source; any identified as such were relocated at the time of identification. The Administrator and the Maintenance Manager reviewed the NFPA 101 (2000 edition) and the NFPA 101 (2012) edition to determine/understand the definition of adjacent to an ignition source to ensure that all wall dispensers are installed appropriately in the future. The Maintenance Manager installs all wall dispensers. The Administrator will observe for appropriate placement of all ABHR dispensers during daily rounds, Monday through Friday. Results of these rounds will be reported monthly to the Safety Committee and included in the quarterly report by the Safety Committee to the Quality Improvement	9/29/13

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K 211	Continued From page 6 o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.	K 211	Executive Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, QI Nurse and any other persons required to provide information pertinent to the reports being presented and discussed at the Executive QI Committee meeting. The Executive QI Committee will make recommendations for further action such as more staff education, change in process, procedure or policy based upon data presented.		