

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Plan of Action Fair Oaks Health Systems Standard Survey 8/11-8/14/15	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.  F 157 Physician Notification Fair Oaks Health Systems shall immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).  Criteria 1: Resident #21 has expired.  Criteria 2: An audit of the 24 hour shift report for the last 30 days was completed by the Administrative Nursing Staff (Director of Nursing, MDS Nurses, and Unit Managers) on 9/2/15 to identify all changes in resident condition (including any symptoms requiring notification of the MD prior to administration of an enema), and to determine that the MD	

RECEIVED  
SEP 24 2015  
Division of Health Care Enforcement

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

TITLE

Administrator

(X5) DATE

9/23/15

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: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's Constipation Protocol, it was determined the facility failed to notify the physician of abdominal distention prior to administration of an enema as directed in the facility's protocol for one (1) resident (Resident #21) in a selected sample of twenty-three (23) residents.  The findings include:  Review of the facility's "Constipation Protocol," not dated, revealed any resident who had no bowel movement in three days would be placed on the daily Constipation Protocol list. Additional review revealed all residents on the Constipation Protocol list would be assessed for bowel sounds and abdominal distention. Further review revealed if any resident experienced abdominal distention, fever, nausea, vomiting, or any other gastrointestinal problem, the physician would be contacted.  Review of the facility's policy and procedure titled "Physician Notification," not dated, revealed the policy was to immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status, or a need to alter treatment significantly. Additional review revealed all notifications and/or attempted notifications would be documented in the nurse's notes.  Record review revealed the facility admitted Resident #21 on 05/28/09 with diagnoses that	F 157	was notified of these changes. There were no changes identified in which MD notification had not been completed.  <b>Criteria 3:</b> Licensed Practical Nurse (LPN) #2 and Director of Nursing (DON) have received inservice education on the need to immediately inform the physician and family of resident changes (including any symptoms requiring notification of the MD prior to administration of an enema), and to document this notification, as provided by the Facility Nurse Consultant, and Director of Clinical Services on 9/2/15. Facility RN's and LPN's have received inservice education on the need to immediately inform the physician and family of resident changes (including any symptoms requiring notification of the MD prior to administration of an enema), and to document this notification, as provided by the Facility Nurse Consultant, Director of Nursing (DON), and Director of Clinical Services on 9/2/15 and 9/10/15.  <b>Criteria 4:</b> The Quality Assurance Performance Improvement (QAPI) indicator tool (see Attachment # 1) for the monitoring of physician notification of changes will be utilized weekly x 4 weeks, then monthly X 2 months and then quarterly under the supervision of the DON. If an accepted threshold of compliance is not achieved, the DON shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting. The Administrative Nursing Staff will review the 24 hour nursing	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 2</p> <p>included Cerebral Palsy, Neurogenic Bladder, Constipation, and history of Paralytic Ileus (obstruction of the intestine due to paralysis of the intestinal muscle).</p> <p>Review of the Monthly Physician's Orders dated 08/01/15 revealed Lactulose 10 grams (g) per 15 milliliters (ml) twice daily and 30 ml daily as needed for "no bowel movement." Additional review revealed an order for Senokot 8.6 milligrams (mg) every day as needed if no bowel movement in three days. Further review revealed an order for a Tap Water Enema (TWE) every Sunday Night until clear and TWE as needed if no results from Lactulose or Senokot.</p> <p>Review of the facility's Bowel Movement Report revealed Resident #21 had a large bowel movement on 07/30/15 at 5:57 PM but had no bowel movements documented for 07/31/15 or 08/01/15.</p> <p>Review of a Nurse's Note dated 08/02/15 at 12:00 AM, revealed Resident #21 was noted with a temperature of 101.3 degrees Fahrenheit (F) and a small amount of brown liquid emesis (vomit). Further review revealed Resident #21's abdomen was noted to be slightly distended and he/she was administered a TWE. However, there was no documented evidence the physician was notified prior to administration of the TWE per protocol related to the fever, distention, and emesis.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 08/14/15 at 10:06 AM revealed she came on duty on 08/01/15 at 10:00 PM. LPN #2 stated she worked until approximately 6:00 AM on 08/02/15. LPN #2 stated she was told in report</p>	F 157	<p>reports daily to identify any resident changes. They will then review the chart to determine that physician and family notification has been completed and documented. (See Attachment #1)</p> <p><b>Criteria 5: September 10, 2015</b></p>	9/10/15	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 that Resident #21 was on the Constipation Protocol list. She stated she administered the TWE because he/she was scheduled to get a TWE on the next day and she thought since he/she was on the Constipation Protocol list she would go ahead and get the TWE out of the way. LPN #2 stated she did not call the resident's physician prior to administering the TWE per the facility's Constipation Protocol and stated she was not aware that she should have done so.  Interview with the On-Call Physician on 08/13/15 at 6:10 PM, revealed he was not notified on 08/02/15 of Resident #21's condition and stated he would have expected to be notified.  Interview with the Director of Nursing (DON) on 08/14/15 at 3:42 PM, revealed it was her expectation for staff to follow the policy and procedures and facility protocols. The DON stated LPN #2 should not have administered the TWE and should have notified the physician.	F 157		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to provide ongoing activities to meet the residents' interests and psychosocial	F 248	<b>F 248 Activities</b> Fair Oaks Health Systems shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  <b>Criteria I:</b> The enteral pump has been exchanged on 8/31/15 to a more mobile one for Resident #6, allowing Resident # 6 to be assisted more easily to multiple different indoor and outdoor activities as per the plan of care. The family of Resident #6 did not want the resident to have their own television, so resident is assisted to the resident lounge	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	<p>Continued From page 4</p> <p>well-being for one (1) of twenty-three (23) sampled residents (Resident #6). The facility, after assessing Resident #6 as enjoying multiple different indoor and outdoor activities, failed to afford the residents the opportunity to enjoy indoor and outdoor activities.</p> <p>The findings include:</p> <p>Review of the Activity Program policy, no date, revealed the Activities Director was aware of the interests and activity needs of each resident and scheduled an enhancement program of both group and individual activities to meet these needs. This schedule was recorded on an activity calendar and presented to the Resident Council monthly for approval. The policy defined an activity as anything that occurred during the waking hours of a resident's day that was not medical or medically oriented in nature, which a resident does during the hours he/she is awake to fill his/her leisure time.</p> <p>An interview with a family member of Resident #6 on 08/11/15 at 12:19 PM revealed the family member visited several times a week. The family member stated she was concerned that the facility was not doing enough activities with the resident. The family member further stated the resident "loved being outside," but stated facility staff "never takes [the resident] out." The family member also stated that the resident "loves music," and was not taken to music activities by staff. The family member stated, "They used to come do things in [the resident's] room one on one and they don't do that as often."</p> <p>Review of the facility's activity calendar for August 2015 revealed that outside time was from 11:00</p>	F 248	<p>area for television viewing as per the plan of care. A radio was placed beside Resident #6's bed for listening as per the plan of care on 8/31/15.</p> <p><b>Criteria 2:</b> All residents are receiving various activities as per plan of care have been assessed to indicate a preference to multiple different indoor and outdoor activities as per the plan of care, and are assisted to the various activities as per the plan of care. All residents who indicate a preference to watch television, but do not have a TV. of their own, are assisted to the resident lounge as desired/care planned for TV viewing.</p> <p><b>Criteria 3:</b> Certified Nursing Assistant (CNA) #1 has received inservice education on assisting residents to multiple different indoor and outdoor activities as per the resident's plan of care as provided by the Facility Nurse Consultant, and Director of Clinical Services on 9/2/15.</p> <p>Activities Director has received inservice education on assisting residents to multiple different indoor and outdoor activities as per the resident's plan of care as provided by the Facility Nurse Consultant, and Director of Clinical Services on 9/2/15.</p> <p>Director of Nursing (DON) and Administrator have received inservice education on assisting residents to multiple different indoor and outdoor activities as per the resident's plan of care as provided by the Director of Clinical Services on 8/31/15.</p>	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	<p>Continued From page 5</p> <p>AM to 11:30 AM and 3:00 PM to 3:30 PM Monday through Friday; Singing every Tuesday at 10:00 AM; and different Church Services Monday through Friday at 6:30 PM.</p> <p>Review of Resident #6's medical record revealed the facility admitted the resident on 04/02/10 with diagnoses of Allergic Rhinitis, Senile Dementia, Generalized Anxiety Disorder, Depression, Paralysis, Brain Disease, Seizure Disorder, and Aphasia. Review of the quarterly MDS (Minimum Data Set) assessment dated 06/30/15, revealed the resident to have a BIMS (Brief Interview for Mental Status) score of 99, which indicated that Resident #6 was not interviewable. Review of the annual MDS assessment dated 11/11/14 revealed the Preferences for Customary Routine &amp; Activities assessed were family/friends, music, groups and favorite activities.</p> <p>Review of the activity care plan, revised 07/03/15, revealed the resident's activity interests included the outdoors, television, movies, and country and gospel music.</p> <p>Review of the activity participation record for August 2015 for Resident #6 revealed the resident watched television on 08/11/15, and had socialization on 08/12/15. Activities scheduled for 08/11/15 were singing at 10:00 AM, outside time at 3:00 PM, and church group at 6:30 PM.</p> <p>Observation of Resident #6 on 08/11/15 at 12:19 PM revealed the resident was lying in bed. The resident did not have a television or radio on her side of the room. Further observations conducted on 08/11/15 at 2:00 PM, 4:14 PM, 5:55 PM, and 6:30 PM revealed Resident #6 was not outside the resident's room during any of the</p>	F 248	<p>All staff have received inservice education on assisting residents to multiple different indoor and outdoor activities as per the resident's plan of care as provided by the Director of Nursing (DON) and Director of Clinical Services on 9/2/15, and 9/10/15.</p> <p><b>Criteria 4:</b> Activity participation will be monitored by the Director of Social Services weekly x 4 weeks, then monthly X 2 months, and then quarterly thereafter to determine that all residents are assisted to participate in preferred activities, including television viewing, in accordance with their plan of care. If an accepted threshold of compliance is not achieved, the Director of Social Services shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting. (See Attachment #2)</p> <p><b>Criteria 5:</b> September 10, 2015</p>	9/10/15

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	<p>Continued From page 6</p> <p>observations. On 08/12/15 at 9:50 AM the resident was observed sitting in a geri-chair in the front lobby by the door by him/herself and no television within sight.</p> <p>Observation on 08/11/15 at 10:45 AM revealed live singing in the Activities Room and on 08/11/15 at 3:15 PM, a group of residents was observed sitting outside on the front porch of the facility. Observations revealed Resident #6 was not present at these activities.</p> <p>Observation on 08/12/15 at 10:50 AM revealed a church group singing in the Activities Room and on 08/12/15 at 3:25 PM, a group of residents was observed sitting outside on the front porch. Resident #6 was not observed at these activities.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 08/12/15 at 4:40 PM revealed that volunteers read to Resident #6 "every now and then." CNA #1 stated staff gets the resident up from time to time, but they do not take the resident to church, singings, or outside because the feeding pump usually is going all through the day. The CNA stated that sometimes church groups would go into the resident's room a couple of times a week.</p> <p>Interview with the Activities Director on 08/12/15 at 4:47 PM revealed that Resident #6 does not have a television in his/her room. The Activities Director stated that she documented television for the resident's activity participation record but should have documented music. The Activities Director further stated the CNAs do not always get the resident out of bed, but when they do, they take the resident to activities. The Activities Director stated, "I get lost sometimes on what to</p>	F 248			

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	Continued From page 7 do." The Activities Director further stated it was difficult to take care of the social work issues and take care of activities with only two (2) activities employees.  Interview with the Director of Nursing (DON) on 08/12/15 at 3:50 PM revealed that activities staff sometimes asked the CNAs to get residents up for different events and that she would expect the CNAs to get Resident #6 up for activities.  Interview with the Administrator on 08/13/15 at 4:08 PM revealed that the activity participation records should reflect what activities each resident participated in and that if Resident #6 did not watch television on 08/11/15, then the activity participation record should not have said it did. The Administrator stated that the facility offers a variety of activities for the residents.	F 248			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278	<b>F 278 Assessment Accuracy/Coordination Fair Oaks Health Systems' assessment shall accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse shall sign and certify that the assessment is completed. Each individual who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment.</b>  Criteria 1: Corrections have been completed in accordance with the RAI correction process, to the MDS assessment for Resident #2 to accurately reflect the range of motion status on 8/31/15.		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	<p>Continued From page 8</p> <p>false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to complete a Minimum Data Set (MDS) assessment to accurately reflect one (1) of twenty-three (23) sampled residents' (Resident #2) status. Review of Resident #2's MDS revealed a functional limitation in range of motion impairment on one side of the body. However, observations on 08/11/15 revealed Resident #2 had impairment in range of motion on both sides of the body.</p> <p>The findings include:</p> <p>Interview with the Administrator on 08/14/15 at 3:25 PM revealed the facility follows the Resident Assessment Instrument (RAI) related to accurately documenting for the Minimum Data Set (MDS).</p> <p>Review of Resident #2's medical record revealed the facility admitted Resident #2 on 04/19/13 with diagnoses that included Congestive Heart Failure, Hyperlipidemia, Aphasia, Dementia, and</p>	F 278	<p><b>Criteria 2:</b> MDS assessments completed within the last 3 months have been reviewed by the Interdisciplinary Team (IDT) on 9/1/15 to verify that resident range of motion status is accurately coded. Corrections were completed for any errors identified. No other assessments require correction.</p> <p><b>Criteria 3:</b> MDS Coordinator, Director of Nursing (DON), and Unit Manager have received inservice education by the Director of Clinical Services and Facility Consultant Nurse on 9/2/15 on the need to double check the accuracy of MDS coded items prior to completion and transmission of MDS assessments.</p> <p>The Interdisciplinary Team (IDT) has received inservice education by the Director of Clinical Services and Facility Consultant Nurse on 9/2/15 on the need to double check the accuracy of MDS coded items prior to completion and transmission of MDS assessments.</p> <p><b>Criteria 4:</b> The QAPI indicator tool (see Attachment # 3) for the monitoring of accuracy of the MDS assessments will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON. If an accepted threshold of compliance is not achieved, the Director of Nursing (DON) shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting. (See Attachment #3)</p>		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 278	<p>Continued From page 9</p> <p>Left Sided Hemiplegia. Review of the quarterly Minimum Data Set (MDS) assessment dated 06/09/15 revealed the facility assessed Resident #2 to have partial paralysis impairment on one side of his/her body. Resident #2 did have diagnoses of Left sided Hemiplegia; however, observations of Resident #2 on 08/11/15 at 1:40 PM, 3:15 PM, 4:15 PM, 5:10 PM, and 5:50 PM revealed Resident #2 had limited range of motion in the left hand and in the right hand, with a hand roll inside the right hand.</p> <p>A telephone interview conducted on 08/12/15 at 11:00 AM with Resident #2's daughter revealed the resident had required the use of the hand roll in his/her right hand for over a year.</p> <p>Interview with the MDS Coordinator on 08/13/15 at 8:45 AM revealed the Unit Managers were responsible for putting new orders and diagnoses in the chart, which allowed her to accurately fill out an MDS. She further revealed if she had been notified of the limited range of motion in Resident #2's right hand, then she would have coded the MDS differently.</p> <p>Interview with the Unit Manager on 08/13/15 at 9:00 AM revealed the CNAs or floor nurses were responsible for keeping her informed of any changes with the residents.</p> <p>Interview with the Director of Nursing (DON) on 08/14/15 at 3:40 PM revealed she randomly assisted with reviewing the MDS assessments for accuracy and had not identified any concerns with MDS accuracy in the facility.</p>	F 278	Criteria 5: September 10, 2015	9/10/15
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F 281 Services Provided Meet Professional Standards	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 10</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy and procedures, it was determined the facility failed to provide services to meet professional standards of quality and follow the facility policy and procedure related to medication administration for one (1) of twenty-three (23) sampled residents (Resident #1). The facility failed to ensure a physician's order was followed related to a new order to discontinue Namenda (medication used to treat dementia) and begin Aricept (medication used to treat dementia).</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled "Preparation and General Guidelines for Medication Administration," not dated, revealed medications would be administered as prescribed and in accordance with good nursing principles and practices.</p> <p>Interview with the Administrator on 08/14/15 at 3:40 PM revealed the facility did not have a policy on following the physician's orders.</p> <p>Record review revealed the facility admitted Resident #1 on 04/15/15 with diagnoses that included Senile Dementia, Hypertension, Hypothyroidism, and Osteoarthritis. Further review of the Monthly Physician Orders for July 2015 revealed an order for Namenda 10</p>	F 281	<p>The services provided or arranged by Fair Oaks Health Systems shall meet professional standards of quality.</p> <p><b>Criteria 1:</b> The orders for Resident #1 to discontinue the Namenda and start Aricept were identified and corrected with the August changeover on 8/1/15 by the Unit Manager. The current orders for Resident #1 were reviewed by the Unit Manager and Director of Clinical Services on 8/11/15 and determined to be accurate.</p> <p><b>Criteria 2:</b> All resident orders for the last 30 days were compared with the MARs to determine that they were transcribed accurately, as completed on 8/31/15 by the Administrative nurses and on 9/1/15 by pharmacy consultants.</p> <p><b>Criteria 3:</b> LPN#3 is no longer employed as of 8/22/15.</p> <p>Inservice education has been provided for Unit Manager (UM) #2 by the Facility Consultant Nurse and Director of Clinical Services on 9/2/15 on the accurate transcription of medication orders to the MARs, and the need to have a second medication administration staff member double check medication transcription after it is completed.</p> <p>Inservice education has been provided for DON by the Facility Consultant Nurse and Director of Clinical Services on 9/2/15 on the accurate transcription of medication orders to the MARs, and the need to have a second medication administration staff member</p>		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281	<p>Continued From page 11 milligrams (mg) twice a day.</p> <p>Review of a Physician's Order dated 07/25/15, revealed a new order to discontinue Namenda and begin Aricept 10 mg every day.</p> <p>Review of the facility Medication Administration Records (MARs) for July 2015 and August 2015, revealed Resident #1 continued to received Namenda 10 mg twice a day and was administered 11 doses from 07/26/15 through 07/31/15. Further review revealed the Namenda was discontinued and the new order for Aricept began on 08/01/15.</p> <p>Interview with LPN #3 on 08/13/15 at 11:30 AM revealed she received the new order to discontinue the Namenda and begin the Aricept. LPN #3 stated she would normally update the MAR immediately and stated she did not. LPN #3 stated she was going to update the MAR when the medications arrived from the pharmacy, but her shift was over before it arrived. LPN #3 stated she reported the new orders to the oncoming nurse during the shift change report but stated she should have updated the MAR.</p> <p>Interview with Unit Manager (UM) #2 on 08/14/15 at 3:34 PM, revealed she identified the Aricept was omitted and corrected the MAR for August 2015. UM #2 stated she also discontinued the Namenda at that time. She stated it was the facility's process for the nurse who receives a new order to update the MAR immediately.</p> <p>Interview with the Director of Nursing (DON) on 08/14/15 at 3:42 PM, revealed it was her expectation for the staff to update the MAR with any new medication changes and to follow all</p>	F 281	<p>double check medication transcription after it is completed.</p> <p>Inservice education has been provided for licensed nursing staff by the Facility Consultant Nurse, and Director of Clinical Services on 9/2/15 and 9/10/15 on the accurate transcription of medication orders to the MARs, and the need to have a second medication administration staff member double check medication transcription after it is completed.</p> <p><b>Criteria 4:</b> The QAPI indicator tool (See Attachment # 4) for the monitoring of compliance with accurate transcription of orders to the MARs will be utilized monthly X 2 months and then quarterly as per the established QAPI calendar under the supervision of the DON. If an accepted threshold of compliance is not achieved, the Director of Nursing (DON) shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting. (See Attachment # 4)</p> <p><b>Criteria 5:</b> September 10, 2015</p>	9/10/15
-------	---	-------	---	---------

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 12 physician orders.	F 281			
F 282 SS=D	<p>Interview with the Physician on 08/13/15 at 6:10 PM revealed he was not aware that his orders had not been carried out to discontinue the Namenda and begin the Aricept. He stated he expected his orders to be carried out.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure services were provided by qualified persons in accordance with the written plan of care for two (2) of twenty-three (23) sampled residents (Resident #6 and Resident #18). Review of the Activity Care Plan for Resident #6 revealed the resident's activity interests included the outdoors, television, movies, and listening to country/gospel music. Resident #6 was not observed to be involved in any of these activities during the survey. According to the plan of care for Resident #18, TED hose (compression stockings) would be applied to the resident's legs every morning and taken off before bed. Resident #18 was observed not to be wearing TED hose although the Certified Nursing Assistant (CNA) signed that the care had been provided.</p>	F 282	<p><b>F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b> The services provided or arranged by Fair Oaks Health Systems shall be provided by qualified persons in accordance with each resident's written plan of care.</p> <p><b>Criteria 1:</b> All refusals are documented, with the MD notified after 3 consecutive days of refusal to wear the TED stockings. The MD discontinued Resident#18's TED stockings on 8/27/15.</p> <p>The enteral pump has been exchanged on 8/31/15 to a more mobile one for Resident #6, allowing Resident # 6 to be assisted to multiple different indoor and outdoor activities as per the plan of care more easily. The family of Resident #6 did not want the resident to have their own television, so resident is assisted to the resident lounge area for television viewing as per the plan of care. A radio was placed beside Resident #6's bed for listening as per the plan of care on 8/31/15.</p> <p>Resident #6 receives activities in accordance with their care plan as</p>		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 13</p> <p>The findings include:</p> <p>Review of the facility's policy, "Resident's Plan of Care," with a revision date of 03/2011 revealed which professional services were responsible for each element of care.</p> <p>1. Review of the medical record for Resident #18 revealed the facility admitted the resident on 07/11/12 with diagnoses including Weakness with Falls, Senile Dementia, Non-Thrombocytopenic Purpura, Hypertension, and Type II Diabetes Mellitus. Review of the quarterly MDS (Minimum Data Set) assessment dated 07/21/15, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 3, which indicated that Resident #18 was severely impaired cognitively. Review of the Comprehensive Care Plan dated 04/16/14 revealed Resident #18 had an intervention for TED hose to be applied with morning care and removed during evening care.</p> <p>Observation on 08/13/15 at 4:00 PM, revealed Resident #18 was not wearing his/her TED hose per care plan. He/she had on short white socks.</p> <p>Interview with CNA #2 on 08/13/15 at 6:00 PM via phone revealed she routinely provided care for Resident #18. She stated the resident did have TED hose that he/she was supposed to wear daily to be put on in the morning, and off at bedtime. She stated he/she would wear them most of the time if he/she was out of bed, but refused to wear them once he/she was in bed. She also stated that all of the CNAs have a care plan they follow for each resident with their level of care and any specialty equipment the resident required. Furthermore, after the CNA performed all areas of care they were to sign the back of the</p>	F 282	<p>determined by care observations completed by the Director of Social Services on 8/31/15, 9/1/15, and 9/2/15. This includes assistance to the Resident #6's activity interest of the outdoors, television, movies, and listening to music.</p> <p><b>Criteria 2:</b> All residents were assessed and evaluated to receive activities and the use of TED stockings in accordance with the resident care plan as determined by care observations completed by the DON, Activities Director, and Unit Managers on 9/1/15. All refusals are documented, with the MD notified after 3 consecutive days of refusal to wear the TED stockings.</p> <p><b>Criteria 3:</b> CNA #2, Unit Manager #1, and LPN #1 have received inservice education by the Consultant Nurse, and Director of Clinical Services on 9/2/15 on the need to provide activities and the use of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal.</p> <p>CNA #1, and Activity Director have received inservice education by the Consultant Nurse, and Director of Clinical Services on 9/2/15 on the need to provide activities and the use of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal.</p> <p>Director of Nursing and Administrator have received inservice education by the Director of Clinical Services on 8/31/15 on</p>	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 14</p> <p>care plan form on the appropriate date. CNA #2 revealed that she was responsible for Resident #18's care on 08/13/15 and that she signed off as doing his/her care for the day. She also stated that she did not help dress Resident #18 on 08/13/15, but a fellow CNA dressed the resident. She knew the resident did not have his/her TED hose on and assumed the resident refused to wear them but did not verify that information. She stated she was not aware of an area to mark "refused" on the care plan. She stated that CNAs were supposed to inform the charge nurse if the resident refused any care areas. The CNA further stated, "I realize I should not have signed my name to the back of the care plan if I did not perform all areas of care."</p> <p>Interview with Unit Manager #1 on 08/13/15 at 6:15 PM revealed the CNA had a care plan for each resident that they followed based on the resident's level of care. She stated there was an area on the back of the CNA Care Plan Record for the CNA to sign after they finished providing all care to the residents. She stated that Resident #18 required the use of TED hose daily. She stated that the resident would normally wear them when he/she was out of bed but preferred not to wear them while in bed. Furthermore, she stated that the aide should inform the nurse if the resident refused care or would not let the CNAs apply his/her TED hose. She stated the CNAs should document on the back of the CNA Care Plan Record that the resident refused TED hose. She stated she had not been aware of any issues with the CNAs signing that they did care when they did not.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 08/13/15 at 6:20 PM revealed Resident #18</p>	F 282	<p>the need to provide activities and the use of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal</p> <p>Nursing staff have received inservice education by the Consultant Nurse, Director of Nursing (DON), and Director of Clinical Services on 9/2/15 and 9/10/15 on the need to provide activities and the use of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal.</p> <p><b>Criteria 4:</b> The QAPI indicator tool for the monitoring of the provision of care (See Attachment# 5) in accordance with the care plan will be utilized monthly X 2 months and then quarterly thereafter under the direction of the Director of Nursing.</p> <p>This tool includes review and observation of resident care to determine that residents are being provided care with in accordance with the residents' plan of care. If an accepted threshold of compliance is not achieved, the Director of Nursing (DON) shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting.</p> <p>Activity participation will be monitored by the Director of Social Services monthly X 2 months, and then quarterly thereafter to determine that residents are assisted to</p>	
-------	--	-------	--	--

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 15</p> <p>had TED hose to wear daily. Furthermore, she stated the resident was sometimes noncompliant and refused to wear them while in bed. She stated the CNAs were supposed to circle what care areas the resident refused and document "refused" on the back of the care plan.</p> <p>Interview with the Director of Nursing (DON) on 08/14/15 at 3:34 PM revealed she had care plan meetings quarterly, with new admissions, and with significant change in health. The Unit Managers updated the residents' care plans. The DON stated the CNAs had a copy of each resident's care plan in their binders. She also stated that TED hose use was on the CNA Care Plan Report. She stated the Unit Managers reviewed the CNA care plan monthly to make sure the care plans were up to date. She stated the nurse was responsible for making sure the CNA was performing the care that was on the care plan. The DON stated if the CNA does not do something that is on the care plan they need to let the charge nurse know and write beside the care area that it was refused.</p> <p>Interview with the Administrator on 08/14/15 at 3:40 PM revealed he believes when a CNA signed the back of the CNA Care Plan Record, she was stating she followed the care plan and performed all areas of care that the resident needed. He stated the facility does not have a policy on following the care plan.</p> <p>2. Review of the Activity Program policy, no date, revealed the Activities Director was aware of the interests and activity needs of each resident and scheduled an enhancement program of both group and individual activities to meet these needs. This schedule was recorded on an</p>	F 282	<p>participate in preferred activities in accordance with their plan of care. If an accepted threshold of compliance is not achieved, the Director of Nursing (DON) shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting. (See Attachment# 2)</p> <p>Criteria 5: September 10, 2015</p>	9/10/15
-------	--	-------	---	---------

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 16</p> <p>activity calendar and presented to the Resident Council monthly for approval. The facility defined activities as anything that occurs during the waking hours of a resident's day that is not medical or medically oriented in nature, which a resident does during the hours he/she is awake to fill his/her leisure time.</p> <p>An interview with a family member of Resident #6 on 08/11/15 at 12:19 PM revealed the family was concerned that the facility was not doing enough activities with the resident. The family member further stated the resident "loved being outside," but stated facility staff "never takes [the resident] out." The family member also stated that the resident "loves music" but was not taken to music activities by staff. The family member stated, "They used to come do things in [the resident's] room one on one and they don't do that as often."</p> <p>Review of Resident #6's medical record revealed the facility admitted the resident on 04/02/10 with diagnoses of Allergic Rhinitis, Senile Dementia, Generalized Anxiety Disorder, Depression, Paralysis, Brain Disease, Seizure Disorder, and Aphasia. Review of the quarterly MDS (Minimum Data Set) assessment dated 06/30/15, revealed the resident to have a BIMS (Brief Interview for Mental Status) score of 99, which indicated that Resident #6 was not interviewable. Review of the annual MDS assessment dated 11/11/14 revealed the preferences for customary routine and activities assessed were family/friends, music, groups, and favorite activities.</p> <p>Review of the activity care plan, dated 04/15/10 and revised 07/03/15, revealed the resident's activity interests included the outdoors, television, movies, and country and gospel music. The care</p>	F 282			

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 17</p> <p>plan stated Social Services, Activities, and Nursing would assist Resident #6 to attend social activities that are mentally therapeutic, encourage family to bring in familiar objects from home that reflect prior life style, one-on-one based activities with daily caregiving to provide sensory and tactile stimuli, and Nursing would provide use of a geri-chair.</p> <p>Review of the facility's activity calendar for August 2015 revealed that outside time was from 11:00 AM to 11:30 AM and 3:00 PM to 3:30 PM Monday through Friday.</p> <p>Review of the activity participation record for August 2015 for Resident #6 revealed it was documented that the resident watched television on 08/11/15 and had socialization on 08/12/15.</p> <p>Observation of Resident #6 on 08/11/15 at 12:19 PM revealed the resident was lying in bed. The resident did not have a television or radio on his/her side of the room. Further observations conducted on 08/11/15 at 2:00 PM, 4:14 PM, 5:55 PM, and 6:30 PM revealed Resident #6 was not outside of the resident's room during any of the observations. On 08/12/15 at 9:50 AM the resident was observed sitting in a geri-chair in the front lobby by the door by him/herself and no television within sight.</p> <p>Observation on 08/11/15 at 10:45 AM revealed live singing in the Activities Room and on 08/11/15 at 3:15 PM, a group of residents was observed sitting outside on the front porch of the facility. Observations revealed Resident #6 was not present at these activities.</p> <p>Observation on 08/12/15 at 10:50 AM revealed a</p>	F 282		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 18 church group singing in the Activities Room and on 08/12/15 at 3:25 PM, a group of residents was observed sitting outside on the front porch. Resident #6 was not observed at these activities.  Interview with CNA #1 on 08/12/15 at 4:40 PM revealed that volunteers usually read to Resident #6 and they get him/her up from time to time, but stated she has never taken him/her to church, singings, or outside because the resident's feeding pump usually is going all through the day, but sometimes church groups will go into the resident's room.  Interview with the Activities Director on 08/12/15 at 4:47 PM revealed they try to follow the plan of care, but sometimes the residents are not out of bed to take to certain activities so they try to do one on one when they aren't up; volunteers help out a lot but it's still hard with only two full-time Activities staff members.  Interview with the DON on 08/12/15 at 3:50 PM revealed that the Activities staff sometimes comes and asks the CNAs to get residents up for different events and she would expect the CNAs to follow the care plan for Resident #6.  Interview with the Administrator on 08/13/15 at 4:08 PM revealed that the staff should be following the plans of care and facility policies.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	<b>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b> Each resident must receive and Fair Oaks Health Systems shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 19</p> <p>accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure necessary care and services to attain the highest practicable physical well-being were provided for two (2) of twenty-three (23) sampled residents (Resident #18 and Resident #21). Review of the medical record for Resident #18 revealed a physician's order, dated 08/15/12, for the resident to have TED hose (compression stockings) on in the morning and off at bedtime. However, the facility failed to provide the TED hose as ordered by the physician to Resident #18. In addition, the facility failed to follow the Constipation Protocol prior to administration of an enema for Resident #21.</p> <p>The findings include:</p> <p>Interview with the Administrator on 08/14/15 at 3:40 PM revealed the facility did not have a policy on following the physician's orders.</p> <p>1. Review of the medical record for Resident #18 revealed the facility admitted the resident on 07/11/12, with diagnoses that included Hypertension, Type II Diabetes Mellitus, Weakness with falls, Senile Dementia, Depressive Disorder, Lack of Coordination, Non-Thrombocytopenic Purpura, Malaise, and Fatigue. Review of the physician's orders for Resident #18 revealed an order dated 08/15/12,</p>	F 309	<p>being, in accordance with the comprehensive assessment and care plan.</p> <p>Criteria #1: Resident #21 has expired.</p> <p>All refusals are documented, with the MD notified after 3 consecutive days of refusal to wear the TED stockings. The MD discontinued Resident#18's TED stockings on 8/27/15.</p> <p>Criteria #2: All residents are assessed to provide bowel management interventions in accordance with the MD's order and facility protocol, including the indicated notification of the MD for symptoms prior to the administration of an enema, as determined by the Unit Manager review of the BM logs and daily shift reports on 9/1/15.</p> <p>All residents with TED Stockings orders are assessed, and are assisted to wear TED stockings as they will allow. All refusals are documented, with the physician notified after 3 consecutive days of refusals on 9/1/15.</p> <p>Criteria #3: CNA #2, Unit Manager #1, and LPN#1 have received inservice education by the Consultant Nurse, and Director of Clinical Services on 9/2/15 on the need to provide bowel management interventions in accordance with the facility protocol, including notification of the MD for the indicated symptoms, and the use of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal.</p>		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 20 for "TED hose to be on in the AM and off at bedtime."</p> <p>Observation on 08/13/15 at 4:00 PM revealed the resident in bed without TED hose in place. The resident was observed to be wearing short white socks.</p> <p>Interview with Certified Nursing Assistant (CNA) #2 on 08/13/15 at 6:00 PM via phone revealed she provided care to Resident #18 during the morning shift on 08/11/15, 08/12/15, and 08/13/15. She was aware the resident was to have TED hose on every morning and off at bedtime. She stated the resident did not like them on while he/she was in bed. CNA #2 also stated the resident was in bed when the TED hose were attempted to be put on and the resident refused because he/she does not like to wear them while in bed.</p> <p>Interview with Unit Manager #1 on 08/13/15 at 6:15 PM, revealed she was aware that Resident #18 was ordered to have TED hose on every day in the morning and off at bedtime. She stated the CNA was responsible for putting the TED hose on the resident but that the nurse was responsible to make sure the CNA puts them on the resident. She also stated that Resident #18 would wear his/her TED hose while out of bed, but preferred not to wear them while he/she was in bed. The CNA was supposed to make the nurse aware if the resident was refusing any areas of care.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 08/13/15 at 6:20 PM revealed she made rounds to make sure the CNAs were doing the resident's care based on their needs. She stated Resident #18 was "bad about taking the TED</p>	F 309	<p>LPN#4 has received inservice education by the Consultant Nurse, Director of Nursing (DON) and Director of Clinical Services on 9/2/15 on the need to provide bowel management interventions in accordance with the facility protocol, including notification of the MD for the indicated symptoms, and the use of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal.</p> <p>Director of Nursing (DON) has received inservice education by the Consultant Nurse, and Director of Clinical Services on 9/2/15 on the need to provide bowel management interventions in accordance with the facility protocol, including notification of the MD for the indicated symptoms, and the use of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal.</p> <p>Nursing staff have received inservice education by the Consultant Nurse, Director of Nursing (DON) and Director of Clinical Services on 9/2/15 and 9/10/15 on the need to provide bowel management interventions in accordance with the facility protocol, including notification of the MD for the indicated symptoms, and the use of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal.</p> <p><b>Criteria #4:</b> The Unit Managers or Charge Nurse will review the BM logs and</p>		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 21</p> <p>hose off" after they were put on. She also stated the resident would refuse to wear them while he/she was in bed. Furthermore, she stated the CNAs were responsible to inform the nurse if the residents refused any care.</p> <p>Interview with the Director of Nursing (DON) on 08/14/15 at 3:34 PM revealed she was aware that TED hose were on the CNA Care Plan Record. She also stated the nurse is responsible for making sure the CNAs perform the care the residents require.</p> <p>2. Review of the facility's "Constipation Protocol," not dated, revealed any resident who had no bowel movement in three days would be placed on the daily Constipation Protocol list. Additional review revealed all residents on the Constipation Protocol list would be assessed for bowel sounds and abdominal distention. Further review revealed if any resident experienced abdominal distention, fever, nausea, vomiting, or any other gastrointestinal problem, the physician would be contacted. Additionally, residents with multiple laxatives ordered on an as needed basis should receive the laxative in order of least invasive first to most invasive last.</p> <p>Record review revealed the facility admitted Resident #21 on 05/28/09 with diagnoses that included Cerebral Palsy, Neurogenic Bladder, Constipation, and history of Paralytic Ileus (obstruction of the intestine due to paralysis of the intestinal muscle).</p> <p>Review of the Monthly Physician's Orders dated 08/01/15, revealed Lactulose (laxative) 10 grams (g) per 15 milliliters (ml), twice daily. In addition, review of the physician orders revealed Lactulose</p>	F 309	<p>shift report daily to determine that residents have been provided bowel management interventions in accordance with the facility protocol. The Bowel Management intervention findings will be reviewed by the QAPI committee in the QAPI meetings. (See Attachment #5).</p> <p>The QAPI indicator tool (See Attachment #5) for the monitoring of the provision of care in accordance with the care plan will be utilized monthly X 2 months and then quarterly thereafter under the direction of the Director of Nursing. This tool includes review and observation of resident care to determine that residents are being provided care in accordance with the residents' plan of care. If an accepted threshold of compliance is not achieved, the DON shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting.</p> <p>Criteria #5: September 10, 2015</p>	9/10/15

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 22</p> <p>30 ml daily as needed for "no bowel movement." Additional review revealed an order for Senokot (laxative) 8.6 milligrams (mg) every day as needed if no bowel movement in three days. Further review revealed an order for a Tap Water Enema (TWE) every Sunday night until clear and TWE as needed if no results from Lactulose or Senokot.</p> <p>Review of the facility's Bowel Movement Report revealed Resident #21 had a large bowel movement on 07/30/15 at 5:57 PM but had no bowel movements documented for 07/31/15 and 08/01/15.</p> <p>Review of a Nurse's Note dated 08/02/15 at 12:00 AM, revealed Resident #21 was noted with a temperature of 101.3 degrees Fahrenheit (F) and a small amount of brown liquid emesis (vomit). Further review revealed Resident #21's abdomen was noted to be slightly distended and the resident was administered a TWE. There was no documented evidence the physician was notified per facility protocol prior to administration of the TWE.</p> <p>Interview with LPN #4 on 08/14/15 at 10:06 AM revealed she came on duty on 08/01/15 at 10:00 PM. LPN #4 stated she worked until approximately 6:00 AM on 08/02/15. LPN #4 stated she was told in report that Resident #21 was on the Constipation Protocol list. She stated she administered the TWE because the resident was scheduled to get a TWE on the next day and she thought since he/she was on the Constipation Protocol list she would go ahead and get the TWE "out of the way." LPN # 4 stated she did not call the resident's physician prior to administering the TWE and stated she was not aware she was</p>	F 309			

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	Continued From page 23 required to.  Interview with On-Call Physician #1 on 08/13/15 at 6:10 PM, revealed he was not notified on 08/02/15 of Resident #21's condition and would have expected to have been notified.  Interview with the DON on 08/14/15 at 3:42 PM, revealed it was her expectation for staff to follow the policy and procedures and facility protocols. The DON stated LPN #4 should not have administered the TWE and should have notified the physician.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure one (1) of twenty-three (23) sampled residents (Resident #2) received appropriate treatment and services to increase range of motion and/or to prevent further risk of injury. Observations of Resident #2 on 08/11/15 revealed Resident #2 to be holding a hand roll in his/her right hand and had limited range of motion/contractures in the right hand. Review of the record for Resident #2 revealed the limited	F 318	F 318 INCREASE/ PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, Fair Oaks Health Systems shall ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  Criteria 1: Resident #2 has been assessed by therapy on 8/24/15. The care plan for resident #2 has been reviewed/revised to address the resident's therapy recommendations, hand range of motion status and the necessary interventions, as completed by the MDS Coordinator on 8/25/15.  Criteria 2: An audit has been completed by the MDS Coordinators on 9/1/15 to determine that the care plans for all residents with limitations in range of motion address this status and the	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 318	<p>Continued From page 24</p> <p>range of motion had not been assessed or a care plan developed to address the resident's right hand.</p> <p>The findings include:</p> <p>Interview with the Administrator on 08/14/15 at 3:25 PM revealed the facility follows the Resident Assessment Instrument (RAI) for their policy and procedures and does not have a specific policy for range of motion or restorative services.</p> <p>Review of Resident #2's medical record revealed the facility admitted Resident #2 on 04/19/13 with diagnoses that include Congestive Heart Failure, Hyperlipidemia, Aphasia, Dementia, and Left Sided Hemiplegia. Review of the quarterly Minimum Data Set (MDS) assessment dated 06/09/15 revealed the facility assessed Resident #2 to have impairment on one side related to the resident's diagnosis of left sided hemiplegia. Observations of Resident #2 on 08/11/15 at 1:40 PM, 3:15 PM, 4:15 PM, 5:10 PM, and 5:50 PM revealed Resident #2 also had limited range of motion in the right hand, and utilized a hand roll within the right hand.</p> <p>A review of the care plan dated 03/05/15 for restorative nursing program revealed the facility assessed Resident #2 to be at risk for contractures and/or limited range of motion. Further review of the care plan revealed no interventions were in place to address the limited range of motion for Resident #2's right hand and no interventions to prevent injury.</p> <p>Interview with the MDS Coordinator on 08/13/15 at 8:45 AM revealed she was responsible for formulating and updating the quarterly and annual</p>	F 318	<p>necessary interventions. All residents with limitations in range of motion had this addressed on the care plan.</p> <p><b>Criteria 3:</b> The MDS Coordinator, Unit Manager, and DON have received inservice education on 9/2/15 by Consultant Nurse, and Director of Clinical Services on the need to develop, review and revise the resident's comprehensive plan of care by using the results of the resident assessments and current orders, including but not limited to those pertaining to limitations in range of motion status.</p> <p>The Interdisciplinary Team (IDT) have received inservice education on 9/2/15 by Consultant Nurse, and Director of Clinical Services on the need to develop, review and revise the resident's comprehensive plan of care by using the results of the resident assessments and current orders, including but not limited to those pertaining to limitations in range of motion status.</p> <p>All nursing Staff have received inservice education on 9/2/15 and 9/10/15 by Consultant Nurse, and Director of Clinical Services on the need to develop, review and revise the resident's comprehensive plan of care by using the results of the resident assessments and current orders, including but not limited to those pertaining to limitations in range of motion status.</p>		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/14/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>FAIR OAKS HEALTH SYSTEMS, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 SPARKS AVENUE JAMESTOWN, KY 42629</b>	
(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 318	Continued From page 25 care plans. She further revealed if a resident developed a contracture or limited range of motion, she should be notified, and a care plan intervention should be added to the care plan. The MDS Coordinator stated she was unaware that Resident #2 had a limitation to the right hand.  Interview with the Unit Manager on 08/13/15 at 9:00 AM revealed the Certified Nursing Assistants (CNAs) or floor nurses were responsible for letting the Unit Managers know if any change of condition occurred with a resident. She further revealed if a resident developed a contracture or limited range of motion, she should be notified, and a care plan intervention should be added to the care plan.  Interview with the Director of Nursing (DON) on 08/14/15 at 3:40 PM revealed the facility had care plan meetings quarterly and audits were done randomly to check the care plans for accuracy. She further revealed the family of Resident #2 had actually requested the hand roll for Resident #2's right hand and the family's request should have been added to the care plan. She had not identified any concerns on developing a care plan for range of motion.	F 318	<b>Criteria 4:</b> The QAPI indicator tool (See Attachment #6) for the monitoring of use of the resident assessment to develop, review and revise the resident's comprehensive plan of care will be utilized monthly X 2 months and then quarterly as per the established QAPI calendar under the supervision of the DON. If an accepted threshold of compliance is not achieved, the DON shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting. (See Attachment #6)  <b>Criteria #5:</b> September 11, 2015	9/11/15
F 323 SS=E	483.25(h) FREE OF ACCIDENT 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.	F 323	<b>F 323 Accidents and Supervision</b> Fair Oaks Health Systems shall 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.  <b>Criteria 1:</b> The hot water sensor was repaired by the contracted vendor on 8/13/15 as determined by water	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 26</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures, it was determined the facility failed to provide an environment that was free from accident hazards to prevent accidents related to water temperatures. During the environmental tour, water temperatures were observed over 110 degrees Fahrenheit (F) in nine (9) of ten (10) rooms on one unit of the facility.</p> <p>The findings include:</p> <p>Review of a facility policy and procedure titled "Water Temperatures," not dated, revealed the water temperatures in the resident areas should range between 100-110 degrees Fahrenheit.</p> <p>Observations made with the facility Maintenance Director during the facility environmental tour on 08/13/15 at 12:00 PM, revealed the water temperature was measured at the sink in the following rooms: room 15 measured 115 degrees F, room 16 measured 121 degrees F, room 17 measured 114 degrees F, room 18 measured 117 degrees F, room 19 measured 114 degrees F, room 20 measured 121 degrees F, room 21 measured 115 degrees F, room 22 measured 120 degrees F, and room 124 measured 116 degrees F. Additionally, observations revealed the thermometer was calibrated with ice water prior to obtaining measurement of water temperatures.</p> <p>Interview with the Maintenance Director on 08/13/15 revealed the thermostat was set to heat the water to 110 F. The Maintenance Director stated the temperatures on the unit were above</p>	F 323	<p>temperatures within acceptable parameters verified on 8/13/15 and 8/14/15. The Hot water heater circulator was replaced on 8/21/15 and water temperatures are within acceptable parameters as verified on 8/21/15, 8/26/15, 8/27/15, and 8/31/15.</p> <p><b>Criteria 2:</b> Water temperatures were checked throughout the facility by the Maintenance staff on 8/21/15 to determine that the hot water sensor had been successfully repaired.</p> <p><b>Criteria 3:</b> Maintenance Staff and the Administrator have received inservice education on 9/2/15 by Director of Clinical Services on the need to monitor the water temperatures , and to immediately address any water temperatures out of the acceptable range.</p> <p><b>Criteria 4:</b> The QAPI indicator tool (see Attachment # 7) for the monitoring of water temperatures will be utilized monthly X 2 months and then quarterly as per the established QAPI calendar under the supervision of the Administrator. If an accepted threshold of compliance is not achieved, the Administrator shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting.</p> <p><b>Criteria 5:</b> September 10, 2015</p>	9/10/15
-------	--	-------	--	---------

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27 the 100-110 F and could potentially burn someone.  Interview with the Administrator revealed the temperatures should be between 100-110 degrees F. He stated the problem with the water temperatures was determined to be a "stuck" heating element. The Administrator stated the water temperatures were spot-checked daily and he was unsure how this happened.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy it was determined the facility failed to ensure the medication error rate was less than five (5) percent. During medication administration observation on 08/12/15, thirty-three (33) opportunities were observed and three (3) errors were observed, resulting in a medication error rate of nine (9) percent.  The findings include:  Review of the facility's policy entitled "Preparation and General Guidelines for Medication Administration" (no date) revealed the facility would administer medications as prescribed in accordance with good nursing principles and practices and only by persons legally authorized	F 332	<b>F 332 Free of Medication Error Rates of 5% or more.</b> <b>Fair Oaks Health Systems shall ensure that it is free of medication error rates of five percent or greater.</b> <b>Criteria 1:</b> Resident #A receives the Senokot, Vitamin D, and Glucophage as per MD orders, as determined by med pass observations completed by the Pharmacy Consultant on 9/2/15 and by the Director of Clinical Services on 9/10/15  <b>Criteria 2:</b> Residents receive their medications as ordered with an error rate of less than 5% as determined by med pass observations completed by the Pharmacy Consultant on 9/2/15 and by the Director of Clinical Services on 9/10/15.  <b>Criteria 3:</b> Inservice education was provided for the Certified Medication Technician(CMT) #1 on correct medication administration by the DON, Pharmacy Consultant, and Director of Clinical Services on 9/2/15 including but not limited to: using the 5 rights to administer medications accurately; double checking to determine that all meds are prepared before administration; and signing for medication administration correctly.  Inservice education was provided for the medication administration staff on correct medication administration by the DON, Pharmacy	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	<p>Continued From page 28 to do so.</p> <p>Observation of medication administration on 08/12/15 at 8:37 AM revealed Certified Medication Technician (CMT) #1 administered Glucophage (oral diabetes medication) 500 milligrams (mg) to Resident A. The resident was not observed to receive Senokot (laxative) 8.6 mg or Vitamin C U-D 500 mg during the observation.</p> <p>Review of the Medication Administration Record (MAR) and Physician's orders on 08/13/15 at 5:00 PM, revealed Resident A was ordered Glucophage 1000 mg every morning with a meal. Further review of the MAR and Physician's orders revealed Resident A was ordered to have Senokot (laxative) 8.6 mg one (1) tablet by mouth once daily at 9:00 AM and Vitamin C U-D 500 mg one (1) tablet by mouth daily at 9:00 AM.</p> <p>Interview with CMT #1 on 08/13/15 at 6:00 PM revealed she had seen the two different orders of Glucophage on the MAR and the two boxes of the Glucophage were side by side in the medication cart. She further revealed that maybe the 500 mg Glucophage had been in the box of Glucophage that was labeled 1000 mg. The CMT stated she could not remember whether she gave or did not give the Senokot or the Vitamin C that was ordered.</p> <p>Interview with the Director of Nursing (DON) on 08/14/15 at 4:30 PM revealed she does random audits with the MARs and also will observe CMTs administer medications at different times but not on a daily basis. She further revealed she had not identified any concerns with medication administration.</p>	F 332	<p>Consultant, Director of Clinical Services on 9/2/15 including but not limited to: using the 5 rights to administer medications accurately; double checking to determine that all meds are prepared before administration; and signing for medication administration correctly.</p> <p><b>Criteria 4:</b> Medication administration observations were completed on all medication administration staff by the DON, Unit Managers, Director of Clinical Services and Pharmacy Consultant by 9/10/15 to determine that meds are administered with less than a 5% error rate. (See Attachment # 8)</p> <p>Medication administration observations will be conducted by the DON or Pharmacy Consultant as part of the medication administration staff annual evaluations to determine ongoing compliance with less than 5% error rates.</p> <p>The QAPI indicator Tool for the monitoring of med pass administration observed six nursing staff giving meds per day on a calendar day (See Attachment # 8) will be utilized monthly X 2 months, and then quarterly as per the established QAPI calendar, under the supervision of the DON. If an accepted threshold of compliance is not achieved, the DON shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting.</p> <p><b>Criteria 5:</b> September 10, 2015</p>	9/10/15

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 F 371 SS=E	Continued From page 29 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of facility policies, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for fifteen (15) of one hundred nine (109) residents of the facility who received nutrition from the kitchen. Observations in the kitchen on 08/12/15 revealed the Maintenance Supervisor walking through the kitchen without a hairnet, a Dietary Manager touching the inside portion of the plates and bowls with her bare skin while serving, and staff transporting food uncovered in the hallway.  The findings include:  Review of the facility's policy, "Employee Sanitary Practices," Policy number A:5.8, no date, revealed it is the policy of the facility to promote guidelines for employee sanitary practices. The policy further stated that all employees were to wear hairnets or restraints, clean attire, and clean shoes, and staff was to change aprons when dirty	F 371 F 371	<b>F 371 Dietary Sanitation</b> Fair Oaks Health Systems shall procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute, and serve food under sanitary conditions.  <b>Criteria 1:</b> Maintenance staff utilize hair nets in accordance with infection control standards when performing repairs/work in the dietary areas. Dietary staff utilize silicone hand mitts to access plates and bowls from the plate warmer while serving. Nursing and dietary staff determine that all food items are covered before delivering food trays to resident rooms. All of these were determined by meal preparation and service audits conducted by the Registered Dietician (RD) on 8/13/15  <b>Criteria 2:</b> An audit was completed of the kitchen and meal service by the Registered Dietician (RD) on 9/2/15 to identify any dietary sanitation issues. All identified issues have been addressed as indicated.  <b>Criteria 3:</b> Dietary Manager #1 has received inservice education by the RD on 9/2/15 on the proper use of hair nets in the kitchen, proper hand sanitation and glove use with food preparation, and food delivery in accordance with infection control standards of practice.  Maintenance, Dietary and nursing staff have received inservice education by the RD and Director of Clinical Services on	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 30</p> <p>and/or after changing tasks and at the start of each shift. The following procedures were required for handling clean china, glasses, and silverware: pick up silverware and cups by their handles, pick up dishes by their rims, pick up glasses by their bases, store glasses and cups bottoms up, preferably in the racks in which they were washed, and store clean dry dishes in appropriate liberators, dollies, or shelving.</p> <p>Review of the facility's policy, "Delivery and Return of Trays," effective date 01/01/14 revealed residents would be served foods that were appetizing, appealing, at an appropriate temperature, and in a timely manner. The policy stated that trays would not be transported outside the cart down the hall, to prevent contamination.</p> <p>1. Observations on 08/11/15 at 12:52 PM during the noon meal service revealed Certified Nursing Assistant (CNA) #2 transporting uncovered cake and drinks multiple times in the hallway up to 60 feet from the food cart to a resident's room.</p> <p>Interview with CNA #2 on 08/12/15 at 10:38 AM revealed that she should not have transported the cake down the hall uncovered. CNA #2 stated she was nervous and forgot.</p> <p>2. Observation on 08/12/15 at 8:46 AM revealed that Dietary Manager #1 was touching the food contact surface of plates and bowls with her bare skin at least 15 times during the breakfast meal service.</p> <p>Interview with Dietary Manager #1 on 08/13/15 at 2:54 PM revealed that she did not know that you could not touch the inside portion of the plates and bowls.</p>	F 371	<p>9/2/15 and 9/10/15. on the proper use of hair nets in the kitchen, proper hand sanitation and glove use with food preparation, and food delivery in accordance with infection control standards of practice.</p> <p>Criteria 4: The QAPI indicator tool for the monitoring of dietary sanitation (See Attachment # 9), including but not limited to use of hair nets, handwashing/glove use, and covering of food for resident room delivery will be utilized monthly as per the established CQI calendar under the supervision of the RD. If an accepted threshold of compliance is not achieved, the RD shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting.</p> <p>Criteria 5: September 10, 2015</p>	9/10/15	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 31  3. Observation on 08/12/15 at 8:47 AM revealed the Maintenance Supervisor walked through the kitchen from the back to the front past the serving line without wearing a hair restraint.  Interview with the Maintenance Supervisor on 08/12/15 at 2:59 PM revealed that he assumed he should have been wearing a hairnet, but did not think about it at the time.  Interview with the Registered Dietitian on 08/12/15 at 3:16 PM revealed CNA #2 should not have been transporting trays with uncovered drinks and cake in the hallways, the Maintenance Supervisor should have been wearing a hairnet while in the kitchen, and Dietary Manager #1 should not have been touching the food contact surfaces on the plates and bowls with bare skin.  Interview with the Administrator on 08/13/15 at 4:08 PM revealed that he expected facility policies and procedures to be followed.	F 371			
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure each bathroom for resident use was equipped to	F 463	<b>F 463 Resident Call System-Room / Toilet/Bath</b> <b>The nurses station shall be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</b>  <b>Criteria 1:</b> The call light cords in the public restrooms identified during the survey were repaired/replaced by the maintenance staff on 8/14/15 to achieve the length necessary for safe resident access.  <b>Criteria 2:</b> The call light cords in all of the public restrooms were inspected, and		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 463	<p>Continued From page 32</p> <p>receive calls through a communication system for two (2) of two (2) bathrooms on the E Wing. Observations revealed emergency pull cords, which activated the facility's communication system, were too short to be reached in case of falls.</p> <p>The findings include:</p> <p>Interview with the facility's Administrator on 08/14/15 at 5:10 PM revealed the facility did not have a policy and procedure on a call/communication system.</p> <p>Observation on 08/14/15 at 4:00 PM, revealed two bathrooms on the E Wing with emergency pull cords, which activated the facility's communication system. One bathroom across from the E Wing nurses' station was equipped with a pull cord that measured approximately 8 inches in length. Further observation revealed the pull cord would not be within reach if a resident had fallen or was on the floor. Additionally, the bathroom to the right of the E Wing nurses' station was equipped with a pull cord that measured approximately 24 inches in length. Further observation revealed the pull cord would not be within reach if a resident had fallen or was on the floor. Both bathrooms were unlocked and available for resident use.</p> <p>Interview with the Administrator on 08/14/15 at 5:10 PM revealed he made rounds routinely throughout the facility to monitor for the effectiveness of the facility's call/communication system. Additional interview revealed the Administrator stated he did not realize the pull cords in the two bathrooms would not be within reach if a resident had fallen on the floor.</p>	F 463	<p>repaired/replaced by the maintenance staff on 8/14/15 to achieve the length necessary for safe resident access.</p> <p><b>Criteria 3:</b> Maintenance staff have received inservice education by the Administrator and Director of Clinical services on 9/2/15 on the need to inspect restroom call light cords on a quarterly basis to determine that they are the length necessary for safe resident access.</p> <p><b>Criteria 4:</b> Call light cord length in the public restrooms will be inspected for proper length quarterly by the Maintenance staff as part of the QAPI indicator process for General Environment, under the supervision of the Administrator (See Attachment #10). If an accepted threshold of compliance is not achieved, the Administrator shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting.</p> <p><b>Criteria 5:</b> September 10, 2015</p>	9/10/15	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to assure that clinical records were in accordance with accepted professional standards and practices related to accuracy for two (2) of twenty-three (23) sampled residents (Residents #6 and #18). Resident #6's Activity Participation Record revealed on 08/11/15 Resident #6 was watching television as an activity in his/her room. Resident #6 was observed in his/her room all day on 08/11/15, however, Resident #6 does not have a television in his/her room. Resident #18's Certified Nursing Assistant (CNA) Care Plan Record revealed on 08/13/15 the CNA had applied Resident #18's TED hose (compression stockings) on, however, Resident #18 was observed on 08/13/15 to be without TED hose on.</p>	F 514	<p><b>F 514 Resident Records</b> Fair Oaks Health Systems shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are— <b>complete, accurately documented, readily accessible, and systematically organized.</b></p> <p><b>Criteria #1:</b> The documentation for Resident #18 TED stockings on the Resident's CNA Care Plan Record accurately reflects MD discontinued Resident#18's TED stockings on 8/27/15. All refusals are documented, with the MD notified after 3 consecutive days of refusal to wear the TED stockings.</p> <p>The enteral pump has been exchanged on 8/31/15 to a more mobile one for Resident #6, allowing Resident # 6 to be assisted to multiple different indoor and outdoor activities as per the plan of care more easily. The family of Resident #6 did not want the resident to have their own television, so resident is assisted to the resident lounge area for television viewing as per the plan of care. A radio was placed beside Resident #6's bed for listening as per the plan of care on 8/31/15.</p> <p>The documentation on the resident activity participation log for Resident #6 accurately reflects the activity the resident is being assisted to, as determined by observations compared to the documentation, performed by the Director of Social Services on 9/1/15.</p>	
---------------	--	-------	--	--

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

PRINTED: 09/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 34 (compression stockings) on, however, Resident #18 was observed on 08/13/15 to be without TED hose on.</p> <p>The findings include:</p> <p>Interview with the Administrator on 08/14/15 at 3:40 PM revealed the facility did not have a policy regarding accuracy of records. The Administrator further stated when the CNAs sign the back of the CNA Care Plan Record they are stating the care plan was followed and the resident's care was performed.</p> <p>1. Record review revealed the facility admitted Resident #18 on 07/11/12, with diagnoses that included Hypertension, Non-thrombocytopenic Purpura, Weakness with falls, Lack of Coordination, Type II Diabetes Mellitus, and Senile Dementia.</p> <p>Review of Resident #18's Quarterly Minimum Data Set (MDS) dated 07/21/15, revealed the resident could not be interviewed due to severe cognitive impairment.</p> <p>Review of Resident #18's Comprehensive Care Plan dated 04/16/14 and the CNA Care Plan Record dated August 2015, revealed staff was required to apply the resident's TED hose (compression stockings) every morning with care, and remove every evening during care.</p> <p>Review of Resident #18's CNA Care Plan Record revealed documentation that the TED hose was applied to the resident on 08/13/15 with morning care.</p> <p>Observation of Resident #18 on 08/13/15 at 4:00</p>	F 514	<p><b>Criteria #2:</b> All residents are assessed and evaluated for accurate documentation of residents acceptance or refusals with TED stockings and the assistance to wear TED stockings as they will allow. All refusals are documented, with the physician notified after 3 consecutive days of refusals.</p> <p>All residents are assessed and evaluated for accurate documentation of resident's activity participation as per their plan of care, as determined by observations compared to the documentation, performed by the Director of Social Services on 9/4/15. All residents without their own television for viewing, will be assisted to the resident lounge areas for direct access to the televisions as per their plan of care.</p> <p><b>Criteria #3:</b> CNA #2, Unit Manager #1, and LPN#1 have received inservice education by the Consultant Nurse, and Director of Clinical Services on 9/2/15 on the use and accurate documentation of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal.</p> <p>Director of Nursing (DON) has received inservice education by the Consultant Nurse, and Director of Clinical Services on 9/2/15 on the use and accurate documentation of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal; and on the need to assist residents who do not have their own television to the resident</p>		

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

PRINTED: 09/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 35</p> <p>PM revealed the resident was not wearing his/her TED hose.</p> <p>Interview with CNA #2 on 08/13/15 at 6:00 PM, via phone, revealed she was aware the resident's TED hose were to be applied daily with morning care. She stated that she gets the information she needs to perform resident care from the CNA Care Plan Record. She stated on 08/13/15 that another CNA dressed the resident and she assumed that the CNA put the TED hose on the resident. She also stated that she did not realize the resident did not have on the TED hose until she saw the resident later and noticed they were not on and assumed that Resident #18 had refused to wear them. Furthermore, she stated the resident would sometimes refuse to wear them if he/she was in bed, but would usually wear them if he/she was out of bed. She stated, "I am not aware of anywhere that it can be documented if a resident refuses any areas of care; we can let the charge nurse know." She also stated that she should not have signed her name to the back of the CNA Care Plan Record unless she knew that the resident had his/her TED hose on and all of the resident's care was completed.</p> <p>Interview with Unit Manager #1 on 08/13/15 at 6:15 PM revealed she was aware that Resident #18 had TED hose ordered for daily use. She stated the CNA that was performing the resident's care usually puts the TED hose on the resident. She stated there was an area on the back of the CNA Care Plan Record for the CNA for their specific shift to sign that they had performed all areas of care for the residents that they were assigned for the day. She stated the CNA should inform the nurse if the resident refused care or would not let them apply the TED hose. She</p>	F 514	<p>lounge areas for direct access to a television as per their plan of care and document accurately activity participation.</p> <p>The Activities Director has received inservice education on 9/2/15 by the Administrator, and Director of Clinical Services on the need to assist residents who do not have their own television to the resident lounge areas for direct access to a television as per their plan of care and document accurately activity participation.</p> <p>Nursing staff have received inservice education by the Consultant Nurse, Director of Nursing (DON) and Director of Clinical Services on 9/2/15 and 9/10/15 on the use and accurate documentation of TED stockings in accordance with their care plans, and to document all refusals with notification of the MD after 3 consecutive days of refusal; and on the need to assist residents who do not have their own television to the resident lounge areas for direct access to a television as per their plan of care and document accurately activity participation..</p> <p><b>Criteria #4:</b> The QAPI indicator for the monitoring of the provision of care in accordance with the care plan and accurate documentation (See Attachment # 5) will be utilized monthly X 2 months and then quarterly thereafter under the direction of the Director of Nursing. This tool includes review and observation of resident care to determine that residents are being provided care in accordance with the residents' plan of care</p>		

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

PRINTED: 09/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2015
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 36</p> <p>stated the CNAs should document on the back of the CNA Care Plan Record that the resident refused to have his/her TED hose applied. Furthermore, she stated that she was not aware of CNAs signing that they performed all care areas when they had not. She stated the nurse was responsible for making sure the resident had his/her TED hose on when she did her rounds on the residents.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 08/13/15 at 6:20 PM revealed she was aware that Resident #18 had TED hose that he/she was supposed to wear daily. She stated Resident #18 "is bad for taking the TED hose off" and was "noncompliant a lot." She stated the CNA was supposed to circle the area of care that a resident refused and document "refused" on the back of the CNA Care Plan Record. She also stated that the CNAs were usually good about letting the nurses know if any of the residents refused care.</p> <p>Interview with the Director of Nursing (DON) on 08/14/15 at 3:35 PM revealed that the CNAs have a care plan to follow for each resident. If a resident required TED hose, that would be on the CNA Care Plan Record. She stated the CNAs sign the back of the CNA Care Plan Record stating they had performed any required care the resident needed. She also stated that if the resident refused an area of care the CNA should inform the charge nurse and write beside that area that the resident refused. Furthermore, she stated that the nurse is ultimately responsible for making sure the residents are receiving the care they need from the CNA. She also stated that it was not acceptable for any staff to document that they have performed care on a resident when it had not been done.</p>	F 514	<p>and are accurately documented. If an accepted threshold of compliance is not achieved, the DON shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting.</p> <p>Activity participation will be monitored for accurate documentation by the Director of Social Services monthly X 2 months, and then quarterly thereafter to determine that residents are assisted to participate in preferred activities, including television viewing, in accordance with their plan of care and are accurately documented. (See Attachment #2) If an accepted threshold of compliance is not achieved, the Director of Social Services shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QAPI committee, with updated audit results, at the next QAPI meeting.</p> <p>Criteria #5      September 10, 2015</p>	9/10/15	

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2015
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 37</p> <p>04/02/10 with diagnoses of Senile Dementia, Generalized Anxiety Disorder, Depression, Paralysis, Brain Disease, Seizure Disorder, and Aphasia. Review of the quarterly MDS dated 06/30/15, revealed the resident to have a BIMS (Brief Interview for Mental Status) score of 99, which indicated that Resident #6 was unable to be interviewed.</p> <p>Review of the activity care plan, revised 07/03/15, revealed the resident's activity interest included the outdoors, television, movies, and country and gospel music.</p> <p>Review of the activity participation record for August 2015 for Resident #6 revealed the resident watched television on 08/11/15.</p> <p>Observation of Resident #6 on 08/11/15 at 12:19 PM revealed the resident lying in bed. The resident did not have a television or radio on his/her side of the room. Further observations conducted on 08/11/15 at 2:00 PM, 4:14 PM, 5:55 PM, and 6:30 PM revealed Resident #6 was not outside of the resident's room during any of the observations. On 08/12/15 at 9:50 AM the resident was observed sitting in a geri-chair in the front lobby by the door by him/herself and no television within sight.</p> <p>Interview with the Activities Director on 08/12/15 at 4:47 PM revealed that Resident #6 did not have a television in his/her room, and that she did not know why she documented that Resident #6 watched television, but she should have documented music because Resident #6's roommate's television was on music.</p> <p>Interview with the DON on 08/12/15 at 3:50 PM</p>	F 514		

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

PRINTED: 08/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/14/2015</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>FAIR OAKS HEALTH SYSTEMS, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 SPARKS AVENUE JAMESTOWN, KY 42629</b>
--	---

(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 514	Continued From page 38 revealed the documentation should not say that the resident received an activity when they did not.	F 514		
-------	--	-------	--	--