

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

PRINTED: 10/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/02/2014
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(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
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F 000 INITIAL COMMENTS

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A Recertification Survey was initiated on 09/30/14 and concluded on 10/02/14, with deficiencies cited at the highest Scope and Severity of an "E". KY00022238, KY00022283, and KY00022286 were initiated on 09/29/14 and concluded on 10/02/14, and were Unsubstantiated with no deficiencies cited.

F 241 483.15(a) DIGNITY AND RESPECT OF SS=E INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the "Residents' Rights for Residents in Kentucky Long-Term Care Facilities", provided by the facility, it was determined the facility failed to ensure staff refrained from standing over residents while feeding, and failed to ensure each resident was served and assisted with meal service in a dignified manner, for two (2) of twenty (20) sampled residents, and two (2) of two (2) unsampled residents (#1, #15, A and B). In addition, staff failed to ensure privacy was maintained during the provision of care by not pulling the privacy curtain or closing the door on multiple occasions, for one (1) of twenty (20) sampled residents (#8).

The findings included:

Review of the "Residents' Rights for Residents in

Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.

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The Director of Nursing (DON) counseled SRNAs #5 and #15 on 10/3/2014 regarding ensuring that each resident is cared for in a manner that enhances their dignity and that during mealtimes each resident should be assisted with meals as per their care plan and if a resident is being fed by a staff member, that only one resident per staff member is being fed. If more residents need to be fed by staff, a request for assistance should be made to the nurse and the other residents needing assistance should not be

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/24/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Kentucky Long-Term Care Facilities", provided by the facility, revealed each resident was to be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs.

Review of the facility's policy titled "Feeding of Residents", undated, revealed staff should maintain interaction and be on eye level with residents who required feeding assistance.

Medical record review revealed the facility admitted Resident #1 on 05/31/14 with diagnoses which included Alzheimer's Disease, Anxiety and Depression. Review of the Minimum Data Set (MDS) Assessment dated 07/31/14 revealed a Brief Interview for Mental Status (BIMS) score of three (3), which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #1 was totally dependent for eating.

Review of the medical record revealed Resident #15 was admitted by the facility on 02/04/13 with diagnoses which included Coronary Artery Disease, Hypertension and Gastroesophageal Reflux Disease. Review of the MDS Assessment dated 09/09/14 revealed Resident #15 was unable to complete the BIMS assessment, which indicated severe cognitive impairment. Further MDS review revealed Resident #15 was dependent upon staff for feeding assistance.

Medical record review revealed Unsampled Resident A was admitted by the facility on 09/14/13 with diagnoses which included Alzheimer's Disease, Anxiety and Depression. Review of the MDS Assessment dated 07/20/14

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brought to the dining table until one-to-one assistance by staff could be provided. Also, staff should be seated at the level of the resident while feeding and engage in conversation with that resident; and use the napkin rather than bid to wipe the resident's face as needed.

The Administrator counseled the DON, Assistance Director of Nursing (ADON), LPN#6 and SRNA #11 on October 22, 10/24/14 2014, regarding their responsibilities as staff to respect the privacy of a resident by always pulling the privacy curtain and/or closing the resident room door prior to providing any type assistance or care to a resident.

All residents have the potential to be affected. Residents were visited by the Administrator on 10/21/2014 through 10/23/2014 to identify any other residents affected. Residents were interviewed regarding call light wait times; choices in grooming, activities and dressing; privacy and respect shown by staff. Residents unable to provide answers to the Administrator were observed for dignity issues. All concerns expressed by the residents were addressed with staff and corrected at the time of the discussion with the resident.

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F 241	<p>Continued From page 2</p> <p>revealed a BIMS score of three (3) which indicated the resident was severely cognitively impaired. Continued review of the MDS Assessment revealed Resident A was totally dependent upon staff for assistance with eating.</p> <p>Review of the medical record revealed Unsampld Resident B was admitted by the facility on 03/22/12 with diagnoses which included Congestive Heart Failure and a history of Myocardial Infarction (heart attack). Review of the MDS Assessment dated 07/29/14 revealed a BIMS score of three (3) which indicated severe cognitive impairment. Continued review of the MDS Assessment revealed Resident B was totally dependent for assistance with eating.</p> <p>1. Observation of the evening meal, on 09/30/14 between 5:20 PM and 5:40 PM, revealed Resident #1 and Unsampld Resident B were seated together at a table in the secured unit dining room. Continued observation revealed State Registered Nursing Assistant (SRNA) #15 stood between the two (2) residents while feeding both of them.</p> <p>On 09/30/14 at 5:55 PM, an interview with SRNA #15 revealed she was the only aide in the dining room during the evening meal. She stated she knew she was only to feed one (1) resident at a time, per facility policy, but there were no other aides present. In addition, she stated she should be seated while feeding any residents. Continued interview revealed SRNA #15 stated it was a dignity issue to stand over a resident to feed them, and she should have asked her charge nurse for help.</p> <p>Observation during the noon meal, on 10/01/14 at</p>	F 241	<p>All staff were re-educated 10/14/2014 through 10/16/2014 by the Staff Facilitator, QI Nurse and/or DON with regard to dignity for all residents; and that the facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality; including providing privacy during care and/or assistance, as well as using appropriate dinnerware, napkins and feeding only one resident at a time while sitting at the appropriate level to engage that resident in conversation. This education will be provided to all new employees during orientation.</p> <p>Admin Nurse Team, including the DON, ADON, QI Nurse, MDS Nurses and Staff Facilitator will continue to monitor that resident care is being provided in a manner that respects each resident's dignity as a part of their daily rounds, Monday through Friday. The results of these rounds will be documented on the Daily Rounds QI tool. Any concerns identified during these rounds will be addressed & corrected as indicated. The QI Rounds tools and the results of these rounds will be reported at the weekly QI meeting for four (4) weeks then monthly thereafter.</p>

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12:15 PM, revealed Resident #1 and Resident #15 were seated at a table in the dining room with three (3) other residents who had been served their food and were eating independently. Continued observation revealed Unsampled Resident A was seated at an adjacent table with another resident who had been served and was feeding himself/herself. SRNA #5 was observed to serve the meal to Resident #1 and proceeded to feed him/her. Resident #15 and Resident A did not receive their meals.

Continued observation at 12:35 PM revealed Resident #15 and Resident A still had not received a tray. Further observation, at 12:40 PM, revealed SRNA #5 completed feeding Resident #1 and was observed to wipe the resident's mouth with the clothing protector instead of using a napkin. At 12:45 PM, Resident #15 received a tray and SRNA #5 began feeding the resident; however, Resident A did not receive a tray until surveyor intervention.

On 10/01/14 at 12:45 PM, an interview with SRNA #6 revealed she did not know why Resident A did not receive a tray when the other residents at the table were served. She stated all residents that were able to feed themselves were usually placed at the same table; however, sometimes that was not possible. She further stated the staff should have noticed Resident A did not receive a tray. She revealed this should not have happened, as it could make the resident "feel bad and left out".

On 10/01/14 at 2:48 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed she expected the residents that needed feeding assistance to be grouped together whenever

F 241 The results of these audits will be reported to the DON upon completion and at the weekly QI meeting for four (4) weeks then monthly thereafter. The results of these monthly meetings will be reported quarterly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting. The Executive QI Committee will make recommendations for further action such as more staff education, change in process, procedure or policy or other course of action based upon the data presented.

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possible, and residents that were able to eat independently were seated together as well. Continued interview revealed the aides were to report to her if they needed help. She further stated staff were never to stand over a resident, nor were they to feed more than one (1) resident at a time. She further revealed it is the aides' responsibility to ensure all residents received their trays in a timely manner. In addition, residents' mouths should be wiped with a napkin, not a clothing protector, in order to preserve the residents' dignity.

On 10/02/14 at 5:10 PM, an interview with the Director of Nursing (DON) revealed the aides were trained to respect the residents by attending to them with respect. The aides were to feed only one (1) resident at a time, and should always be sitting and engaging the resident. Continued interview revealed staff members should always use the napkin provided for the purpose of cleaning the residents' mouths. She stated there was a system failure; a resident should never wait 20 minutes or more for their tray. She further stated this was a dignity issue.

On 10/02/14 at 5:50 PM, an interview with the Administrator revealed she leaves the seating arrangements to the nurses' discretion. She stated if there was a shortage of aides to assist the residents with eating, she would expect the aides to ask for help. Continued interview revealed all staff members were to be seated while feeding residents, and should never use a clothing protector in place of a napkin. She acknowledged a failure in communication and stated this presented a dignity issue.

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2. Review of the medical record revealed

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revealed Resident #8 was admitted by the facility on 09/24/13, and readmitted on 05/27/14, with diagnoses which included Hypertension, Dementia and Depression. Review of the MDS Assessment dated 09/08/14 revealed a BIMS score of five (5), which indicated impaired cognitive ability.

Observation of Resident #8, on 10/01/14 at 9:28 AM, revealed LPN #6 and the Assistant Director of Nursing (ADON) assisted the resident to the restroom without closing the curtains or the door to ensure privacy.

Subsequent observation of Resident #8, on 10/01/14 at 12:10 PM, revealed SRNA #11 assisted the resident with repositioning in the bed. The SRNA pulled all the covers off, exposing the resident. SRNA #11 failed to close the curtains or the door to ensure the resident's privacy.

Further observation of Resident #8, on 10/02/14 at 9:19 AM, revealed the DON and the ADON removed all cover from from the resident in order to adjust his/her leg brace, without pulling the privacy curtain or closing the door.

Interview with the ADON, on 10/1/14 at 9:28 AM, revealed the facility's practice for the preservation of privacy and dignity was to close the privacy curtain and the door when providing care to a resident. The ADON stated she should have closed the curtain before she began care, as her failure exposed the resident and had the potential to affect the resident's self-esteem.

Interview with CNA #11, on 10/01/14 at 12:10 PM, revealed she should have closed the curtains before she began care for the resident, to ensure

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F 241	Continued From page 6 his/her privacy. Interview with the DON, on 10/02/14 at 9:19 AM, revealed the curtains should have been pulled before care was provided to the resident. She stated the failure to do so was a privacy and dignity issue for the resident. Interview with the Administrator, on 10/02/14 at 6:34 PM, revealed it was her expectation for staff to provide privacy at all times during the provision of care.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide services in accordance with each resident's written plan of care for two (2) of twenty (20) sampled residents (Resident #1 and #8). Resident #1 was care planned for hip pads after a fall; however, observations on 09/30/14, 10/01/14 and 10/02/14 revealed the hip pads were not on the resident. In addition, Resident #1 continued to wear a seatbelt during observations on three (3) consecutive days after the belt was discontinued by the Physician and the intervention was removed from the care plan. Furthermore, observations on 09/30/14 and	F 282	Hip protectors were placed on Resident #1 as per the care plan on 10/2/2014. The self-releasing seat belt was removed from the wheelchair and room of Resident #1 per the care plan and physician order on 10/2/2014. SRNA #10 was counseled by the DON on 10/2/2014 regarding following the resident care plan by referring to the posted Care Guide in the resident's room prior to providing care. The DON assigned an SRNA to feed lunch and dinner to Resident #8 on 10/2/2014. All SRNAs on duty in the unit Resident #8 resides in were instructed by the DON on 10/2/2014 that Resident #8 required assistance with all meals; as well as, following the resident care plan by referring to the posted Care Guide in the resident's room prior to providing care. All residents have the potential to be affected by the failure of staff to provide	10/24/2014

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10/02/14 revealed staff did not provide feeding assistance for Resident #8 as care planned.

The findings include:

Review of the facility's policy titled "Resident Care Plan", undated, revealed the facility would provide a written care plan based on the Physician's orders and an assessment of each resident's needs.

Review of the clinical record for resident #1 revealed diagnoses included Depressive Disorder, Anxiety, and Alzheimer's Disease.

Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 07/31/14, revealed the facility assessed Resident #1 to have a Brief Interview of Mental Status (BIMS) score of three (3), which indicated the resident was cognitively impaired. Continued review of the MDS Assessment revealed the facility assessed the resident to be at risk for falls. Further review of the clinical record revealed a Physician's order, dated 09/29/14, to discontinue the self-releasing soft seatbelt.

Review of the Comprehensive Plan of Care, dated 04/30/13, revealed the resident experienced a fall on 07/05/14, with the addition of an intervention for the application of hip pads. Further review of the Care Plan revealed no interventions were in place related to a self-releasing seatbelt.

Observation during a skin assessment, on 10/01/14 at 2:40 PM, revealed no hip pads in place. Additional observation, on 10/02/14 at 9:05 AM, revealed Resident #1 to be in bed with no hip pads in place.

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care according to the written plan of care. To identify other residents, rounds to resident rooms to observe care being provided were completed by the Administrator 10/21/2014 through 10/23/2014 to audit for care being provided by staff in accordance with the resident's plan of care. No other residents were identified as being affected.

All staff who provide care to residents including licensed nurses, nursing assistants, activities staff, social services and dietary were educated by the Staff Facilitator, QI Nurse and/or DON 10/14/2014 – 10/16/2014 regarding referring to the plan of care prior to providing care to any resident. Care guides are located inside each resident's closet door for quick easy reference of information contained in the care plan.

To monitor the effectiveness of this education and ensure continued compliance with providing care in accordance with the written plan of care, the Administrative Nursing Team, including the Director of Nurses,

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Observations on 09/30/14 at 4:30 PM, on 10/01/14 at 9:00 AM, 10:00 AM and 11:55 AM, and on 10/02/14 at 9:05 AM revealed Resident #1 to be sitting in a wheel chair with a self-releasing seat belt fastened around the resident.

Interview with State Registered Nursing Assistant (SRNA) #10, who was assigned to the resident at the time of the observation on 10/02/14, revealed she did not think Resident #1 had an order for hip pads, but she would check the Care Guide (a written tool utilized to communicate individual resident care needs and utilized by the nursing assistants). Continued interview revealed SRNA #10 stated, after checking the Care Guide, Resident #1 was to have hip pads in place. Further interview revealed SRNA #10 knew Resident #1 was no longer supposed to have the seat belt, but she could not say why it was on the resident.

Interview with Licensed Practical Nurse (LPN) #5, on 10/02/14 at 10:10 AM, revealed she was aware Resident #1 was to have hip pads on, and it was her responsibility to check the resident every two (2) hours to ensure care was provided as ordered, but she had not made it to the resident's room yet. She stated she did not know why the hip pads were not on the resident for three (3) days. Continued interview revealed the hip pads were used as a safety precaution. Further interview revealed LPN #5 knew the seatbelt for Resident #1 had been discontinued. She stated the seatbelt should not be on the resident.

Interview with the Director of Nursing (DON) on 10/02/14 at 10:15 AM, revealed Resident #1

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

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F 282 Continued From page 9

should have had the hip pads on, and the seatbelt should have been removed from the room when it was discontinued by the Physician. She further stated she expected the nurses and SRNAs to review each resident's care needs, as written on the Comprehensive Care Plan and the Care Guide, and follow the written interventions.

2. Review of Resident #8's medical record revealed the facility admitted the resident on 09/24/13, and readmitted the resident on 05/27/14, with diagnoses which included Anemia, Dementia, Depression, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/08/14, revealed a BIMS score of five (5), which indicated the resident was cognitively impaired. Further review of the MDS revealed the resident required limited assistance of one person with eating.

Review of the Comprehensive Care Plan related to Resident #8's level of assistance needs for eating, dated 04/18/14 and revised 07/02/14, revealed interventions included "Resident is a Feeder". Continued review revealed the resident required assistance to restore or maintain his/her maximum function of self-sufficiency for eating.

Review of Resident #8's Care Guide for September 2014, used to communicate the resident's care needs and utilized by the nursing assistants, revealed interventions included "Resident is a Feeder".

Observation of the evening meal for Resident #8, on 09/30/14 at 5:05 PM, revealed State Registered Nursing Assistant (SRNA) #12 and SRNA #13 entered the resident's room to set up the meal for consumption. SRNA #12 stated

F 282

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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 10 Resident #8 was able to feed himself/herself after tray setup, although it might take a long time. Continued observation revealed Resident #8 complained of back pain, and the SRNAs repositioned the resident to his/her right side in a sitting position; however, the head of the resident's bed was not raised to its fully upright position. Both SRNAs exited the room, leaving Resident #8 to attempt to eat from a slouched position. Further observation, on 09/30/14 at 5:20 PM, revealed Resident #8 attempted to eat but was unable to get the fork to his/her mouth. Staff entered the room to reposition the resident again and LPN #2 instructed SRNA #12 to assist the resident with eating. The SRNA stated she did not know Resident #8 required feeding assistance. Interview with SRNA #12, on 09/30/14 at 5:35 PM, revealed she did not realize Resident #8 required feeding assistance, but she could determine the resident's care needs by reviewing the Care Guide posted on the inside of the closet door. Continued interview revealed the resident should not have been left to feed himself/herself in a slouched position as it could be a choking risk. Subsequent observation, on 10/02/14 at 9:05 AM, revealed Resident #8 in his/her room with the breakfast tray on the overbed table. The resident pushed the tray away with approximately 95% of uneaten food left on the tray. No staff were present in the room. Subsequent interview with the DON, on 10/02/14 at 4:16 PM and 5:32 PM, revealed she did not	F 282			

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F 282 Continued From page 11
know who fed Resident #8 that morning. She stated it was possible the resident had fed himself/herself, or at least attempted to. The DON further stated she had interviewed staff and could not determine who, if anyone, attempted to feed Resident #8 breakfast. Continued interview revealed Resident #8 required assistance with eating, but sometimes refused being fed by staff; however, the DON revealed her expectation for staff to remain with the resident during meals to provide cueing if the resident refused assistance. She further stated the resident should not be left alone during meals.

Interview with the Administrator, on 10/02/14 at 6:34 PM, revealed she defined "Resident is a Feeder" to mean staff should remain with the resident throughout the meal to provide assistance and cueing as needed, and to feed the resident if necessary. Continued interview revealed Resident #8 tired easily and required assistance with feeding to finish a meal. She further stated staff were expected to follow the Comprehensive Care Plan and/or Care Guide written interventions during the provision of care for each resident.

F 323 483.25(h) FREE OF ACCIDENT
SS=E 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 282

F323

F 323 On 10/01/2014, after notification by the Team Leader of the State Survey Team that the facility failed to have a system in place to ensure the environment remained as free of accident hazards as was possible to prevent accidents due to the exit doors to the closed hospital not being alarmed or constantly monitored in some manner to prevent residents from entering the area of the closed hospital that included patient rooms with furniture in them, the Administrator and Maintenance Director placed an alarm

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F 323 Continued From page 12
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents when an unsecured exit door on the North Unit was not identified.

The findings include:

Observation on the North Unit, on 10/01/14 at 12:00 PM, revealed an exit door opening directly into a closed hospital facility was not secured by lock and did not have an alarm in place. Continued observation revealed without a direct line of vision by staff, residents could exit the door and enter the hospital area without staff knowledge.

Observation of the closed hospital on 10/01/14 at 12:10 PM revealed furniture and equipment, including a crash cart and office equipment, stored in the unoccupied rooms. Continued observation revealed a set of fire doors to the left of a nurses' station had a non-functioning alarm. Beyond the fire doors, two (2) hallways with additional former patient rooms led to the emergency room. The emergency room and some of the doors was locked, but many of the rooms were unsecured.

Interview with State Registered Nurse Aide (SRNA) #2, on 10/01/14 at 12:45 PM, revealed the exit door leading to the hospital area did not have an alarm system on it. She stated there was a Wander Guard alarm on the fire doors accessed before reaching the exit door; however, only if a resident was wearing a Wander Guard device would the alarm sound when the doors

F 323 on those doors. This alarm sounds with an extremely loud screech that is audible throughout the north hallway if the doors are exited without the alarm being silenced. The alarm can only be silenced with a key. The alarm does not prevent the doors from being opened thus in the event of a fire the doors can be opened without delay. The alarm sounds when opened without a key to alert staff that the doors have been opened and staff need to respond to the alarm immediately.

All other exit doors within the Nursing Home are equipped with delayed egress locks, alarms and keypads to prevent residents from exiting the doors without staff knowledge of their whereabouts. A visual round was conducted by the Administrator, Maintenance Director & Environmental Services on 10/14/2014 -10/16/2014 to identify any other hazards or risks in the resident's environment and to implement interventions to reduce any hazards or risks identified.

All staff were educated by the Staff Facilitator, QI Nurse and/or DON through mandatory in-services held Tuesday, October 14 and Thursday, October 16, 2014 regarding the alarm on the exit doors from the Nursing Home into the closed Hospital portion of the building. If someone must go

10/17/2014

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F 323 Continued From page 13
were opened.

Interview with the Administrator, on 10/01/14 at 3:00 PM, revealed the exit door to the closed hospital was not monitored and a resident without a Wander Guard device could enter the closed hospital without being noticed and could be injured. She explained the alarm on the fire doors next to the nurses' station in the hospital area was turned off that morning to allow the surveyors access to restrooms. Further interview revealed the facility did not have a policy, but utilized the Quality Improvement Process to prevent incidents/accidents, to investigate incidents when they did occur, and to minimize future occurrences by identifying issues through rounds.

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

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

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

(b) Preventing Spread of Infection

- (1) When the Infection Control Program

F 323 through the doors, they have been directed to get either the Maintenance Director or the Nurse working in the Sunshine Garden hallway to silence the alarm for their exit and to return the alarm back to active status once they have re-entered through the doors.

The Safety Committee, including the Maintenance Director, Housekeeper, QI Nurse, Dietary Manager, Business Office Staff and Administrator will continue to conduct monthly safety inspection rounds to identify any issues that have the potential to create a hazard or risk to the safety of residents, staff and/or visitors. Any concerns identified during these rounds will be addressed & corrected as indicated. The QI Rounds tools and the results of these rounds will be reported monthly at the QI meeting.

F 441 The results of these monthly meetings will be reported quarterly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting. The Executive QI Committee will make recommendations for further action such as more staff education, change in process, procedure or policy or other course of action based upon the data presented.

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F 441	<p>Continued From page 14</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</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 maintain an infection control program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection. Two (2) of five (5) interviewed State Registered Nurse Aides (SRNAs), both working on the North Unit, failed to demonstrate proper sanitation of the whirlpool. In addition, an SRNA transported soiled linen and a soiled breakfast tray out of the locked South Unit, with un-gloved hands, and into and back out of a resident's room before proceeding to dispose of the items on another unit in the facility.</p> <p>The findings include:</p> <p>1. Review of the facility's "Procedure for</p>	F 441	<p>F441</p> <p>SRNAs #3 and #9 were re-educated by the Staff Facilitator on 10/2/2014 regarding the procedure for proper sanitation of the whirlpool tubs.</p> <p>SRNA # 10 was counseled by the QI/Infection Control Nurse on 10/2/2014 regarding her disregard of following proper infection Control Practices with regard to proper handling of soiled linen, hand washing practice, and disposal of the resident tray remains.</p> <p>All residents have the potential to be affected by the failure of staff to follow the policies and guidelines of the Infection Control Program. Rounds were conducted by the Admin Nurse Team including the DON, ADON, QI Nurse, MDS Nurses and Staff Facilitator during the week of 10/13/2014 – 10/17/2014 to identify any other infection control concerns. Identified concerns were corrected as appropriate.</p> <p>All staff who provide care/support to residents including licensed nurses, nursing assistants, activities staff, social services, housekeeping, laundry, business office and dietary were educated by the Staff</p>	10/24/14
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F 441 Continued From page 15
Sanitizing Whirlpool Tubs", undated, revealed a nine (9) step procedure for proper sanitation of whirlpools. Review of the fourth step of the procedure revealed instructions to place the spray head of the sanitizer into the jet intake valve and wait until the sanitizer was observed to come out of the spray valve located under the tub faucet, to ensure coating of the jet piping with the sanitizer. Continued review of the seventh (7) step of the procedure revealed, after ten (10) minutes had elapsed, the blue hose was to be placed into the jet intake valve and hot water was to run through for two (2) minutes to ensure thorough rinsing of the jet piping.

Observation of the tub room, on 10/02/14 at 9:28 AM, revealed the sanitizing procedure was posted on the wall above the whirlpool.

Interview with SRNA #3, on 10/02/14 at 9:28 AM, revealed several residents enjoyed using the whirlpool. She stated she provided an average of one (1) whirlpool bath each shift. She further stated she had been trained to sanitize the whirlpool both prior to and following each resident use. During SRNA #3's explanation of how to properly sanitize the whirlpool, she did not mention running the sanitizer through the jet intake valve until the sanitizer was observed to come out of the spray valve located under the faucet, as outlined in Step Four of the written procedure. To clarify, SRNA #3 demonstrated the procedure for sanitizing the whirlpool. Continued observation revealed the SRNA was able to demonstrate all steps correctly, with the exception of Step Four and Step Seven, as outlined above.

Interview with SRNA #9, on 10/02/14 at 10:17

F 441 Facilitator, QI Nurse and/or DON 10/14/2014 – 10/16/2014 regarding proper infection control practices, including but not limited to hand washing, sanitation of whirlpool tubs, appropriate handling of linens.

To monitor the effectiveness of this education and ensure continued compliance with the Infection Control Program, the Administrative Nursing Team, including the Director of Nurses, Assistant Director of Nurses, QI Nurse, MDS Nurses and Staff Facilitator will monitor that resident care is being provided in accordance with the Infection Control Program through daily rounds, Monday through Friday. The results of these rounds will be documented on the Daily Rounds QI tool. Any concerns identified during these rounds will be addressed and corrected as indicated. The results of these rounds will be reported at the weekly QI meeting for four (4) weeks; then monthly thereafter. The results of these weekly/monthly QI meeting will be reported quarterly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information

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F 441 Continued From page 16

AM, revealed she had been trained to sanitize the whirlpool both prior to and after each use. She stated three (3) or four (4) residents used the whirlpool daily. Observation of SRNA #9's demonstration of the procedure used to sanitize the whirlpool revealed she, too, did not perform Steps Four and Seven correctly, according to the written procedure.

Interview with the Administrator on 10/02/14 at 10:37 AM revealed it was her expectation for staff to properly sanitize the whirlpools, in accordance with the written protocol. She stated, in addition to orientation, staff had received additional education on the procedure earlier in the year. The Administrator further acknowledged improper sanitization of the whirlpool could contribute to the spread of infection.

Interview with the Infection Control Nurse, on 10/02/14 at 5:45 PM, revealed if the whirlpool was not sanitized effectively between resident uses, the potential for cross-contamination was a concern.

2. Review of the facility's policy titled "The Infection Control Program", not dated, revealed the objective was to prevent and control the transmission of communicable infectious disease to the extent possible.

Review of the facility's policy titled "Linen Handling Policy", dated 09/2014, revealed all soiled linen should be considered as contaminated. Continued review revealed soiled linens should be handled as little as possible for minimum agitation and to prevent microbial contamination of the air and of staff handling the linen. Further review revealed soiled linen should

F 441

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

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F 441	<p>Continued From page 17</p> <p>be bagged and/or placed in containers at the location where it is used.</p> <p>Review of the facility's policy, titled "Handwashing Policy", dated 09/2014, revealed staff were required to wash their hands after each direct or indirect resident contact.</p> <p>Observation, on 10/01/14 at 9:25 AM, revealed SRNA #10 responded to a call light in a resident's room on the South Unit while carrying a bag of soiled linens and a soiled breakfast tray from elsewhere on the unit, with her un-gloved hands. Upon entering the resident's room, the SRNA placed the breakfast tray on the sink counter and carried the soiled linen bag into the resident's bathroom. Continued observation revealed SRNA #10 picked the breakfast tray up from the sink and carried it and the linen bag back out of the room, off the South Unit and onto the North Unit for disposal. Throughout the observation, SRNA #10 did not wash, sanitize or glove her hands.</p> <p>Interview with SRNA #10, on 10/01/14 at 9:25 AM, revealed she "messed up". She stated the resident's emergency bathroom light was sounding and she was concerned about the residents' safety. She explained the soiled breakfast tray had been left behind when the food cart was taken from the South Unit and she had to take the tray to the North Unit to dispose of it. She further stated there was a concern of cross-contamination when she carried soiled items into a resident's room.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 10/02/14 at 3:20 PM, revealed there was a dirty utility room located on the South Unit. She</p>	F 441			

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F 441 Continued From page 18

stated the soiled linen should not have been carried further away as the bag could break, spreading germs and infection from one resident to another resident. She further stated the soiled tray should not have been placed on the sink. In addition, the SRNA should have washed or sanitized her hands before and after any resident care. Continued interview revealed the SRNA should also have worn gloves, in addition to handwashing, while handling contaminated items.

F 441

Interview with the Infection Control Nurse, on 10/02/14 at 3:35 PM, revealed the SRNA should have left the dirty linens in the dirty utility room on the South Unit. She stated germs could be spread by carrying dirty linens out of the unit. She further stated the soiled linen and the tray should not have been carried together. In addition, she explained, the SRNA should not have entered the resident's room with the soiled items, and should have washed her hands due to the potential for spreading germs.

Interview with the Director of Nursing (DON), on 10/02/14 at 5:00 PM, revealed staff should wash their hands before and after resident care is provided. She stated improper hand washing and handling of soiled items increased the potential to spread germs. Continued interview revealed the soiled linens should have been placed in the dirty utility closet nearest the South Unit and the tray should have carried to the other unit separately.

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70 (a)

BUILDING: 01

PLAN APPROVAL: 1962. Renovated in 1994

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected

SMOKE COMPARTMENTS: Five (5) smoke compartments.

COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM Installed in 1991 and upgraded in 1994.

FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) Installed in 1994

EMERGENCY POWER: Type II Diesel Generator installed in 1979.

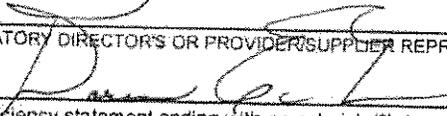
A Life Safety Code Survey using the 2786S (short form) was conducted on 09/30/14 with deficiencies cited. The facility was not in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility is licensed for one hundred four (104) beds with a census of ninety five (95) the day of the survey.

The highest Scope and Severity was at the "F" level.

K 000

Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.

NOV 24 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin	(X6) DATE 10/24/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 10/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(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
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K 072 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.
7.1.10

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure exit egress was maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, four (4) residents, staff and visitors.

The findings include:

Observation on 09/30/14 at 3:37 PM, with the Maintenance Director, revealed furniture in the lobby corridor. The furniture included two (2) benches, two (2) potted plants, and a small table. None of the items were secured to the floor or wall and the benches projected greater than (2) feet into the corridor. Interview with the Maintenance Director revealed he had failed to secure the items to the wall or floor and confirmed the items projected greater than two (2) feet into the corridor.

Reference: NFPA 101 (2000 edition)
7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

K 072
K072

One bench, two (2) potted plants and a small table were removed from the lobby corridor on 10/20/2014. The remaining bench was secured to the floor by Maintenance staff on 10/20/2014.

10/21/14

The Maintenance Director surveyed the remaining corridors within the facility on 10/20/2014 to determine that all other means of egress were free of all obstructions or impediments to full instant use in the case of fire or other emergency.

All staff were educated 10/14/2014 – 10/16/2014 regarding the need to keep all means of egress free from obstructions in the event of an emergency or fire.

The Safety Committee, including the Maintenance Director, Housekeeper, QI Nurse, Dietary Manager, Business Office Staff and Administrator will continue to conduct monthly safety inspection rounds to identify any issues that have the potential to create a hazard or risk to the safety of residents, staff and/or visitors including obstructions in the means of egress that would impede instant use in the event of fire or other emergency. Any concerns identified during these rounds will be addressed & corrected as indicated. The QI

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K 072 Continued From page 2
7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof.

K 130 NFPA 101 MISCELLANEOUS
SS=F
OTHER LSC DEFICIENCY NOT ON 2786

This STANDARD is not met as evidenced by:
Based on observation, record review, and interview it was determined the facility failed to ensure the emergency generator annunciator panel was at a location that was constantly monitored, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, one hundred four (104) residents, staff and visitors.

The findings include:

Observation on 09/30/14 at 3:09 PM, with the Maintenance Director, revealed the emergency generator annunciator was at a location not constantly attended. The location was past a set of smoke barrier doors that were between the nursing facility and the hospital. A lamp test of the emergency generator annunciator was conducted by the Maintenance Director. The alarm was unable to be heard at the closest constantly attended nurses' station. Interview with the Maintenance Director revealed the location of the emergency generator annunciator was monitored by nursing staff from hospital, but

K 072: Rounds tools and the results of these rounds will be reported monthly at the QI meeting. The results of these monthly meetings will be reported quarterly to the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting. The Executive QI Committee will make recommendations for further action such as more staff education, change in process, procedure or policy or other course of action based upon the data presented.

K130

The emergency generator annunciator will be moved from the closed hospital nurses station into the North Nursing Home Nurses' Station by maintenance staff under the direction of the Maintenance Director who is a licensed electrician. 11/7/14

A written policy regarding the reading of the annunciator and what to do and who to contact in the event of an alarm has been developed by the Administrator.

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K 130: Continued From page 3

the hospital had closed down approximately four (4) months ago. Further interview revealed the nursing facility has been making rounds at one (1) hour intervals checking the emergency generator annunciator. Record review of the log found in the area of the emergency generator confirmed nursing staff were checking the emergency generator annunciator every hour. Further interview with the Maintenance Director revealed the facility had discussed moving the generator with vendors, but had not made a decision as to who would perform the relocation of the emergency generator annunciator. Further interview with the Maintenance Director revealed the facility did not have a written policy stating who would contact Maintenance if the facility was using the emergency generator and an alarm activated on the emergency generator annunciator after hours while maintenance was not present. The practice had been for the Charge Nurse to notify Maintenance after hours for emergency generator annunciator alarms.

The findings were confirmed with the Maintenance Director.

Reference NFPA 101 (2000 edition)

3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the

K 130:

All staff will be in-serviced with regard to the newly written policy by the Staff Facilitator. In-services to be completed 10/30/2014. At the time the panel is being moved.

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K 130 Continued From page 4 K 130

emergency or auxiliary power source as follows:

(a) Individual visual signals shall indicate the following:

1. When the emergency or auxiliary power source is operating to supply power to load.
2. When the battery charger is malfunctioning.

(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:

1. Low lubricating oil pressure
2. Low water temperature (below those required in 3-4.1.1.9)
3. Excessive water temperature
4. Low fuel -when the main fuel storage tank contains less than a 3-hour operating supply
5. Overcrank (failed to start)

Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually.

[110: 3-5.5.2]