

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

PRINTED: 10/13/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING  OCT 22 2010	(X3) DATE SURVEY COMPLETED  09/29/2010
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NAME OF PROVIDER OR SUPPLIER  JACKSON MANOR	STREET ADDRESS Division of Health Care Southern Enforcement Branch ANNVILLE, KY 40402
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F 000	INITIAL COMMENTS  A standard health survey was conducted on September 27-29, 2010. Deficient practice was identified with the highest scope and severity at 'E' level.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.  This REQUIREMENT is not met as evidenced by:	F 164	As indicated in this statement LPN #1 was knowledgeable of the requirement for privacy but forgot in this instance. For this resident in the future no similar acts will occur. This could affect any resident but in this case no other residents were involved and thus were not affected. This nurse was immediately instructed on the importance of providing privacy during care by the DON on 9/27/10. All nursing staff have been reeducated individually on the importance of privacy by the DON or the ADON; this process being completed by 10/20/10. This topic was discussed at an in-service for all employees on 10/22/10 by the administrator. All facility department heads have been instructed to observe for any violations of our privacy policy by the administrator in a staff meeting on 10/18/10 and an reminder e-mail was sent on 10/22/10. Environmental rounds will be made at least monthly by the maintenance director and the housekeeping supervisor and they will	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>J. A. Nelson</i>	TITLE  Adm.	(X6) DATE  10-22-10
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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 the 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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F 164	<p>Continued From page 1</p> <p>Based on observation, interview, and facility policy review, it was determined the facility failed to provide personal privacy for one (1) resident (resident #17) during the administration of medications via a gastrostomy tube.</p> <p>The findings include:</p> <p>Observation of the noon medication pass on September 27, 2010, revealed Licensed Practical Nurse (LPN) #1 prepared one medication for administration via gastrostomy tube (g-tube) for resident #17. LPN #1 was observed to don gloves, check the g-tube placement, and administer the medications through the g-tube. LPN #1 failed to ensure privacy for resident #17 during the g-tube medication administration. The LPN failed to close the door to resident #17's room, did not pull the privacy curtain between the beds, and failed to close the window blinds.</p> <p>Further observation revealed the resident's roommate was in the room and a housekeeper was in the hallway during the medication administration for resident #17.</p> <p>Interview with LPN #1 on September 27, 2010, at 4:00 p.m., revealed the LPN was knowledgeable of the requirement to ensure privacy for residents during a g-tube medication administration. The LPN stated the LPN realized privacy had not been ensured while performing the procedure but was afraid to stop the procedure.</p> <p>A review of the facility policy related to privacy (not dated) revealed privacy curtains were required to be utilized around the resident's bed during care and treatments so the resident would not be exposed to other individuals. The policy</p>	F 164	<p>observe for any violations of the privacy policy. Information from these rounds will be reviewed by the QA committee and acted on as appropriate.</p>	10/29/10

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F 164	Continued From page 2 also stated people not directly involved in examination or treatment of the resident's body would not be present without the resident's consent.	F 164		
F 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure that dignity was maintained for two (2) of seventeen (17) sampled residents (residents #14 and #16). Observation revealed the facility had posted a Functional Maintenance Program sheet on the resident's wall, above the resident's bed. The Functional Maintenance Program sheet was in public view and displayed personal information and included recommended feeding techniques for the residents.</p> <p>The findings include:</p> <p>During the initial tour of the facility conducted on September 27, 2010, at 9:40 a.m., a Functional Maintenance Program sheet was observed taped to the wall above resident #14's bed. The Functional Maintenance Program sheet contained the resident's name and listed the resident's strengths as: verbal, able to follow commands, friendly, and cooperative. The sheet listed resident #14's weaknesses as: unable to feed self. The Functional Maintenance Program sheet</p>	F 241	<p>Interviews with resident # 14 and the guardian of resident # 16 by the administrator on 9/28/10 indicated that they knew that the information had been posted and neither had any objection to this posting. No resident was negatively affected by this since both resident's mentioned were aware of the posting and did not object but the information was removed from the wall on 9/27/10 by the DON. This situation could affect any resident so every room has been checked by the DON or the ADON on 9/28/10 and no PHI is displayed. Nurses, nurse aids, housekeepers and maintenance personnel have been instructed by the administrator on 10/22/10 to observe for PHI displayed in rooms and to notify the administrator or the DON immediately if any is found. Environmental rounds will be made at least monthly by the maintenance director and the housekeeping supervisor and they will for inappropriate postings. Information</p>	

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F 241	<p>Continued From page 3</p> <p>included a feeding plan for resident #14. The plan stated that resident #14 was on a puree diet with nectar-thick liquids, was to be positioned in an upright position/90-degree angle, and staff was to ensure all pureed foods were smooth and creamy. The plan stated staff was to add gravy or milk to foods such as mashed potatoes, breads, etc., as needed to make them smooth and creamy (like pudding). The plan also directed staff to offer the resident a drink after every one to two bites, to position the straw so the resident was in a chin-tuck position, and stated if the resident began to cough, staff was not to offer food/fluids until the coughing had stopped/cleared, and to notify Speech Therapy/Nursing of any coughing at mealtime. The Functional Maintenance Program sheet was signed by the Speech Language Pathologist (SLP); however, no date was listed on the form.</p> <p>Further observation on September 27, 2010, at 11:10 a.m., revealed a Functional Maintenance Program sheet taped to the wall above resident #16's bed. The Functional Maintenance Program sheet contained the resident's name and listed the resident's strengths as: pleasant, cooperative, and responds to simple questions. Further observation revealed the Functional Maintenance Program sheet listed resident #16's weaknesses as: unable to feed self, immobile, and decreased vision. The Functional Maintenance Program sheet included a feeding plan for resident #16 that included the following instructions: 1) Keep resident upright at 90 degrees during all oral intake and 30 minutes after intake. Make sure bed is at 90 degrees and resident is sitting up with no leaning. May take resident's pillow, fold in half, and place behind head. 2) NO STRAWS. 3) Give the resident</p>	F 241	<p>from these rounds will be reviewed by the QA committee .</p>	10/29/10

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F 241	<p>Continued From page 4</p> <p>nectar-thickened liquids in small sips. 4) Encourage the resident to tuck chin toward floor. 5) Encourage extra swallows after bites of solids prior to drink. The Functional Maintenance Program sheet was signed by the SLP, however, no date was listed.</p> <p>Interview on September 28, 2010, at 2:10 p.m., with the SLP revealed residents #14 and #16 had been assessed to require assistance with feeding. The SLP stated during meals these two residents were assisted by staff in the residents' rooms. The SLP stated the Functional Maintenance Program sheet was posted by the SLP to remind staff of the feeding techniques the resident required. The SLP stated the Functional Maintenance Program sheet information was not a privacy concern.</p> <p>Interview on September 28, 2010, at 2:25 p.m., with the Director of Nursing (DON) revealed the DON was not aware of the posting of the Functional Maintenance Program sheet in residents #14 and #16's room. The DON stated residents' private information should not be posted on the walls in resident rooms where the general public could see. Upon review of the Functional Maintenance Program sheet, the DON stated the form disclosed information that should not be available to the public. The DON stated the information should be in the team books used to guide resident care and which were kept at the nurses' station.</p> <p>Review of the facility's policy and procedure for Resident Rights (not dated) revealed residents' personal, medical, and financial records were required to be kept confidential and were only to be utilized by individuals involved in the resident's</p>	F 241		

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F 241	Continued From page 5 care. Further review of the policy and procedure revealed residents had the right to privacy and confidentiality, both personally and regarding their clinical records. The personal privacy included written and oral communications.	F 241		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</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, and record review, it was determined the facility failed to provide services to meet professional standards of quality for two (2) of seventeen (17) sampled residents (residents #6 and #9). Residents #6 and #9 had physician's orders for a bowel protocol; however, the protocols were not followed.</p> <p>The findings include:</p> <p>1. Review of resident #6's medical record revealed the resident was admitted to the facility on July 24, 2008, with diagnoses of Senile Dementia, Hypothyroidism, Alzheimer's Disease, Depression, and Anxiety. Review of the Minimum Data Set (MDS) dated June 30, 2010, revealed the facility assessed resident #6 as being incontinent of bowel and bladder. The resident required total assistance of two staff members for hygiene and bathing. Review of the resident's assessment protocol (RAP) dated June 30, 2010, revealed the resident required adult briefs and the assistance of one to two staff persons for toileting needs. Further review of the RAP revealed</p>	F 281	<p>The facility will follow our bowel protocol for all residents. Changes in the MDS process went into effect on October 1, 2010. The facility has developed new bowel protocols to correlate with these changes. BM's have been recorded for both residents (resident # 6 on 9-29-10 and resident #9 on 9-28-10) listed in the statement with no ill effects. Any resident could be affected and records for all have been reviewed by the DON or the ADON and are in compliance. This review was completed on 10/20/10. Nurses will check the BM tracking sheet each shift to make sure that the bowel protocol is being followed for all those who have triggered. The DON or the Administrator will check our Care Tracker documentation at least once per week and compare this to the tracking form to make sure that the data is consistent ensuring that our bowel protocol is being followed.</p>	

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F 281	<p>Continued From page 6</p> <p>incontinence checks were required to be performed with nursing rounds and as needed.</p> <p>Review of resident #6's physician's orders for September 2010 revealed a bowel protocol was to be utilized for this resident if the resident had no or small bowel movements in the previous nine shifts. The protocol stated the nurse was first required to assess the resident and administer 30 milliliters of milk of magnesia if further intervention was required. If the resident had no adequate bowel movement within eight hours a Dulcolax suppository should be administered. According to the protocol, if the resident continued to have no adequate bowel movement within another eight hours a soap suds enema was to be administered. If the resident had no bowel movement within 24 hours after the need for the first intervention, staff was required to notify the physician.</p> <p>Review of resident #6's bowel elimination record revealed the resident did not have a bowel movement from September 23-28, 2010 (a total of 15 shifts).</p> <p>Review of the facility's "no BM in last six shifts" list revealed resident #6's name had been documented on the list on September 25-27, 2010, by the facility.</p> <p>Review of resident #6's medication administration record (MAR) for September 2010 revealed on September 26, 2010, at 4:00 p.m., 30 milliliters of milk of magnesium was administered to the resident. However, nurse's notes dated September 26-27, 2010, contained no documentation concerning resident #6's bowel movements, and no follow-up to assure the milk</p>	F 281	Results of these reviews will be reviewed by the QA committee.	10/29/10

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F 281	<p>Continued From page 7 of magnesium had been effective.</p> <p>Interview on September 28, 2010, at 10:00 a.m., with Licensed Practical Nurse (LPN) #2 revealed it was the responsibility of the State Registered Nurse Aides (SRNAs) to enter into the computer when a resident had a bowel movement. LPN #2 stated that after nine shifts with no bowel movement the resident would be considered to be constipated. Interview further revealed that at the end of the shift a "no BM in last six shifts" list was printed off the computer and passed on to the next shift, so the bowel movement protocol could be started or continued per the physician's order. LPN #2 stated he/she was unaware of resident #6 being on the no bowel movement list in the last week. Further interview revealed the LPN did not go back to assess resident #6 to ensure the bowel movement protocol was in place or that the milk of magnesia had been effective for this resident. Interview with LPN #2 further revealed according to the MAR no staff followed up to ensure resident #6 had a bowel movement or received the Dulcolax suppository per physician's order.</p> <p>Interview on September 28, 2010, at 4:35 p.m., with Registered Nurse (RN) #3, the night shift nurse who worked on September 26, 2010, revealed the RN was not aware of resident #6 being on the bowel care list. RN #3 stated that the SRNAs recorded the bowel movements into the computer and that the day shift nursing staff should inform the night shift nursing staff if a resident was on the "no BM in last six shifts list" and received bowel protocol, per physician's order. RN #3 stated that the RN was not aware that resident #6 received milk of magnesium on September 26, 2010, nor did the RN remember</p>	F 281		

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F 281	<p>Continued From page 8</p> <p>receiving in report before the shift began about resident #6 being on the bowel care list on September 26, 2010.</p> <p>2. Review of the medical record for resident #9 revealed this resident was admitted to the facility on May 2, 2008, with a diagnosis of Chronic Airway Obstruction, Diabetes Mellitus, Hypertension, Obesity, and Dementia. Resident #9 was assessed on the MDS dated September 15, 2010, to be frequently incontinent of bowel.</p> <p>Review of resident #9's bowel elimination record for September 2010 revealed the resident did not have a bowel movement from September 24-28, 2010. Review of resident #9's MAR for September 2010 revealed staff had failed to initiate the bowel protocol as ordered. Resident #9 did not receive milk of magnesium, Dulcolax suppository, or a soap suds enema in September 2010.</p> <p>Review of resident #9's physician's orders for September 2010 revealed that a bowel protocol had been ordered for this resident when the resident had no or small bowel movements in the previous nine shifts. The protocol stated the nurse should assess the resident and administer 30 milliliters of milk of magnesia if further intervention was required. If the resident had no adequate bowel movement within eight hours after the milk of magnesia, staff was directed to administer a Dulcolax suppository. If the resident did not experience an adequate bowel movement within eight hours after the Dulcolax suppository, staff was then directed to administer a soap suds enema to the resident. If the resident had no bowel movement within 24 hours after the milk of magnesia was administered, staff was required to</p>	F 281		

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F 281	<p>Continued From page 9 notify the resident's physician.</p> <p>Review of the "no BM in last six shifts" list revealed resident #9 was on the list from September 25-27, 2010.</p> <p>Interview with resident #9 on September 29, 2010, at 1:30 p.m., revealed the resident had a bowel movement every day and sometimes twice a day.</p> <p>Interview on September 29, 2010, at 11:50 a.m., with SRNAs #9, #10, and #11 revealed that resident #9 was usually continent of bowel function. The SRNAs stated that when resident had a bowel movement this information was entered into the computer program. According to the SRNAs, the nurse was responsible to inform the SRNAs when a resident's name had been placed on the bowel care list or was receiving medications per the bowel protocol. SRNAs #9, #10, and #11 stated they were unaware that resident #9 had been placed on the bowel care list or that the resident had received any medication per physician's orders for bowel management.</p> <p>Interview on September 29, 2010, at 12:45 p.m., with LPN #3 revealed resident #9 was placed on the bowel care list to receive bowel protocol on Monday September 27, 2010. LPN #3 stated that the bowel care list would have been given to the KMA to provide the bowel care protocol. LPN #3 further stated resident #9 was given milk of magnesium on Monday, September 27, 2010, by the KMA. LPN #3 further stated a follow-up was not conducted to determine if resident #9 had a bowel movement before the end of the LPN's shift.</p>	F 281		

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F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a valid medical justification for the use of an indwelling catheter for one (1) of seventeen (17) residents. Observation on September 27, 2010, revealed resident #1 had an indwelling catheter in place however, the facility failed to provide a written medical diagnosis for the use of the indwelling catheter.</p> <p>The findings include:</p> <p>Resident #1 was admitted to the facility on May 10, 2010, with diagnoses of Diabetes Mellitus, Dementia, Hypertension, Dysphagia, Sepsis, Urinary Tract Infection, and Pneumonia. Review of the Minimum Data Set (MDS) dated May 18, 2010, revealed resident #1 was totally incontinent of bladder. Review of the Resident Assessment Protocol (RAP) dated May 18, 2010, revealed the resident was incontinent of bladder and used adult briefs. Resident #1 was assessed to require the assistance of one to two staff persons for</p>	F 315	<p>No catheter shall be inserted or left in place without a valid diagnosis. The catheter was removed from resident # 1 on 10/4/10. All other resident's with a catheter had their records checked by the DON or the ADON on 10/20/10 and all have an appropriate diagnosis. A nurse on staff who also works at a hospital noted redness to the peri area of resident # 1 and got an order for a catheter without recording a diagnosis to justify its use following hospital protocol rather than our protocol. This nurse was reeducated on our protocol and the differences between our protocol and that of the hospital by the DON on 9/29/10. The DON or the ADON met with all other nursing staff to assure that all were aware of the correct use of and the proper documentation related to catheters. This retraining was completed as of 10/20/10. The DON or her designee will review all catheters in use monthly and make sure that there is a clinical diagnosis for all catheters. Information from these reviews will be reviewed by the QA committee.</p>	10/29/10

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F 315	<p>Continued From page 11 toileting needs.</p> <p>Observation on September 27, 2010, at 1:30 p.m., revealed resident #1 in bed with an indwelling catheter to a bedside drainage bag.</p> <p>Review of resident #1's medical record revealed physician's orders dated August 8, 2010 and September 10, 2010, for a Foley catheter; however, no medical diagnosis was documented.</p> <p>Interview with the MDS Coordinator on September 27, 2010, at 5:40 p.m., revealed the medical record did not contain a medical diagnosis for the use of the indwelling catheter for resident #1.</p> <p>Interview with the DON on September 28, 2010, at 1:20 p.m., revealed the DON was unaware of the reason no attempt had been made to remove the Foley catheter or to obtain a written diagnosis for the use of the indwelling catheter.</p>	F 315		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an environment free of accident hazards</p>	F 323	<p>Staff is aware that no items that are labeled 'Keep out of Reach of Children' is to be left out on shelves, beside tables and etc. For this resident the item was removed on 9-28-10 by the DON. Any resident could be affected like this so all rooms were checked for toxic items on 9-28-10 by the DON. All staff have been retrained by their supervisor on the importance of removing possibly toxic items from</p>	

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F 323	<p>Continued From page 12</p> <p>over which the facility had control for one (1) of seventeen (17) sampled residents (resident #13).</p> <p>The findings include:</p> <p>Observation during the environmental tour on September 28, 2010, at 10:40 a.m., revealed one 16-ounce bottle of Witch Hazel (an astringent) was observed on a shelf in resident #13's room. The bottle had approximately 12 ounces remaining. The Witch Hazel bottle had an expiration date of May 2009. Further observation revealed a warning on the label: Keep out of reach of children. If swallowed, get medical help and contact the Poison Control Center right away.</p> <p>Review of the monthly physician's orders for September 2010 revealed no physician's order for Witch Hazel for resident #13.</p> <p>Interview on September 28, 2010, at 10:45 a.m., with resident #13 revealed the resident's family had brought the Witch Hazel to the facility for the resident a long time ago. Resident #13 stated the resident could not remember what the liquid had been used for.</p> <p>Interview on September 28, 2010, at 2:40 p.m., with the DON revealed the DON was not aware that resident #13 had Witch Hazel at the resident's bedside. The DON stated residents should not have medications at the bedside because the facility did not have any residents that were cognitively able to self-medicate. The DON stated the Witch Hazel could be dangerous if a resident drank the liquid or gave the liquid to another resident. The DON stated the facility had nine residents that were assessed as wandering residents.</p>	F 323	<p>open areas in any resident room by 10/15/10. There was also an in-service for all employees on 10/22/10 when this was discussed to assure that all residents were involved. All supervisory staff were instructed to observe for these items on 10/18/10 by the administrator and he also sent a follow-up e-mail on 10-22-10 as a reminder. These observations are to be made whenever they are in a room and the administrator or his designee will make observations at least weekly to make sure that toxic items have been removed by staff. These observations will be reviewed by the QA committee.</p>	10/29/10

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F 323	Continued From page 13	F 323		
F 364 SS=E	<p>Review of the facility's Material Safety Data Sheet (MSDS) book revealed the following hazards for Witch Hazel:</p> <p>Ingestion: Considered to be moderately toxic. (Ethyl Alcohol) Inhalation: Exposure may cause headache, drowsiness, lassitude, loss of appetite, inability to concentrate, and irritation of throat. Dermal contact: May cause mild irritation.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</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 each resident received food that was at the proper temperature during the evening meal on September 27, 2010.</p> <p>The findings include:</p> <p>Observation of the evening meal on September 27, 2010, at 6:28 p.m., revealed the second set of dining room trays was delivered to the dining room on an open serving cart. The CNAs in the dining room served the trays from 6:50 p.m. until 6:58 p.m. The last tray was selected for a test tray as the tray had remained on the cart for 30 minutes. Food temperatures obtained by the</p>	F 364	<p>According to interviews with the dietary manager the trays left the kitchen at 6:28 and the last tray except for the test tray left the cart shortly after she left the dining room to get a replacement for the test tray at 6:50. The dietary manager returned to the dining room from the kitchen with a replacement meal. All trays were gone from the cart except for the test tray. There were only 5 or 6 trays on the cart and the dietary manager noted that nearly half the food on the trays had been consumed by the time that she took the temperatures on the test tray so she estimated that 3-5 minutes had elapsed from the time that the last tray was served from the cart and the temps were taken. There were no resident complaints related to food temperatures. The facility policy mentioned refers to temperatures when trays arrive on the floor and does not refer to times when the tray reaches the resident. There appears to be no violation of any regulation or facility policy. The resident's involved with these trays ate the food with no complaints so they were not negatively affected. All residents who eat food prepared in the kitchen could be affected but a review by the administrator on 10/20/10 of all times of service recorded on recent QA reviews do not indicate any problems.</p>	

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F 364	<p>Continued From page 14</p> <p>Dietary Manager on the test tray were as follows: sweet potatoes - 128 degrees Fahrenheit, ham - 119 degrees Fahrenheit, broccoli/cauliflower mixture - 117 degrees Fahrenheit, strawberries and banana mixture - 56 degrees Fahrenheit, and ice cream - 18 degrees Fahrenheit.</p> <p>An interview with the Dietary Manager on September 27, 2010, at 7:00 p.m., revealed the Dietary Manager was unsure of the appropriate serving temperature for the foods served or how long a tray should sit on the cart after being delivered to the floor prior to the trays being delivered by staff.</p> <p>An interview with SRNAs #1 and #2 on September 27, 2010, at 7:05 p.m., revealed SRNA #1 stated new trays should have been obtained and delivered to the residents within 20 minutes of arriving to the floor to ensure foods were served at the appropriate temperatures. SRNA #2 stated new trays should be served within 35 minutes of their arrival to the floor.</p> <p>Review of the facility policy for food temperature standards, dated 2006, revealed temperatures for sliced entrees, vegetables, and starches should be at a minimum of 130 degrees Fahrenheit when delivered to the residents, and chilled fruits/salads/desserts should be at a temperature less than 45 degrees Fahrenheit.</p>	F 364	<p>Dietary and nursing staff have been reeducated by the administrator on 10/22/10 on policy related to meal service so that they know limits on times to serve trays and what to do if time limits are not met or if a resident is not satisfied with meal temperatures. The dietician will do a meal audit at least monthly with an audit the next week if problems are found. She will record the times that meals arrive on the unit, times that first trays are passed and the time that the last trays is passed and the temperature of the food at the end of the pass. These audits will be reviewed by the QA committee.</p>	10/29/10
F 463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p>	F 463	<p>The administrator was called to room A-2 because the call bell was allegedly not working. As he entered the room he heard the D.O.N. state that "It works every time for me." Upon enter the bathroom the administrator noted that the string which controlled the call bell had been wrapped around the hand rail several times apparently by:</p>	

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F 463	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain an accessible/fully functional call light system related to the emergency call light system in one (1) resident's bathroom (room A-2).</p> <p>The findings include:</p> <p>Observations during the environmental tour on September 28, 2010, at 1:30 p.m., revealed the emergency call light in resident bathroom A-2 would not activate when the activation string was pulled. Further observation revealed the pull cord was tied to the activator switch; however, the pull cord was improperly installed and had not been threaded into the second eyelet provided on the activator switch.</p> <p>The DON was notified of the malfunctioning emergency call light in the bathroom in resident room A-2 on September 28, 2010, at 5:05 p.m. The DON attempted to activate the emergency call bell in resident room A-2 but was unsuccessful. The DON attempted to notify the Maintenance Supervisor; however, the Maintenance Supervisor had left the facility. The DON notified the Administrator of the malfunctioning emergency call bell.</p> <p>The Administrator and LPN #2 assessed the emergency call bell in resident bathroom A-2. The Administrator was able to activate the emergency call bell at times by pulling on the activator string with much force. The Administrator and LPN #2 removed the activator pull string by cutting the string with scissors and</p>	F 463	<p>the resident making it difficult to pull the cord. The string was unwrapped and the string was pulled with normal pressure and the call bell sounded every time. There was an inappropriately placed knot in the cord which the administrator cut out and the cord was reattached and again the light functioned as designed every time. Follow-up visits to the room by the administrator on 9/28/10 and 9/29/10, and 10/4/10 and by the MDS coordinator on 9/28/10 and 9/29/10 found that the call light worked every time. For the call light to function, a red switch must be pulled down about 1 inch either by pulling down on the switch directly or by pulling down on the attached string. If one were to pull gently on the string, especially when it was wrapped around the rail it may not pull down far enough to activate the switch. The primary cause of the problem seems to be that the string had been tied around the rail by the resident. For the resident involved the call cord was unwrapped from the rail and an inappropriately placed knot was removed by the administrator on 9/28/10 and the call bell worked properly. All residents have call bells so all resident's could be affected so all rooms were checked by the maintenance director on 9/29/10 to make sure that no cords were wrapped around the hand rail and that the call be worked properly. Housekeepers and nurse aids have been instructed to check bathroom call cords when they are in the room to make sure that they are not tied around the hand rail. All staff notification were made on or before 10/22/10. Environmental rounds will be done monthly by the maintenance director and the</p>	

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F 463	Continued From page 16 threaded the string through the proper eyelets.  Interview on September 29, 2010, at 1:05 p.m., with the Maintenance Supervisor revealed the activator string had been installed incorrectly; therefore, the emergency call light could not be activated.	F 463	The results of these rounds will be reviewed by the QA committee.	10/29/10
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Scraped and chipped drywall was observed in four (4) resident rooms, one faucet leaked continuously, support bars were loose, the ceiling was soiled in one resident room, and call bell plates were not tightly secured to the wall.  The findings include:  During the environmental tour of the facility on September 28, 2010, at 10:30 a.m., the following items were in need of repair:  1. The drywall was observed to be scraped in resident rooms A-7, A-12, and C-4. 2. The drywall was observed to be peeling in the bathroom in resident room A-11. 3. Holes were observed in the wall at the head of	F 465	No residents were negatively affected since items mentioned did not cause unsanitary, nonorderly or uncomfortable conditions. But to correct the conditions in the rooms mentioned the drywall in rooms A-7, A-11, A-12 and C-4 were repaired on 9-30-10. The holes in the drywall were patched on 9-30-10 and again on 10-5-10. The loose rails were tightened in the shower room and in rooms A-11 and B-1 on Sept. 30. The ceiling was painted in room A-7 on Oct. 5. The seal was replaced on the facet in room A-10 on Sept. 30. The faucet in room B-3 was tightened on Sept. 30. New screws were put in the call bell system in rooms A-2 and B-1 on Sept. 30 and a loner string was installed on the light in room A-2 on Oct. 5. The trim on the attic access was secured on Oct. 5. All other rooms were checked on Oct. 5 by the maintenance director and no similar problems were found so no other residents were affected (note that most rooms are scheduled to be repainted in the near future). Nursing and housekeeping staff have been instructed by the administrator on or before 10/22/10 to report any environmental concerns to maintenance immediately. Environmental rounds will be conducted by the maintenance supervisor & the housekeeping supervisor monthly to assure compliance. The results of these rounds will be	

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F 465	<p>Continued From page 17</p> <p>the bed in resident room A-1.</p> <p>4. The support bar was observed to be loose in the women's shower room and in resident rooms A-11 and B-1.</p> <p>5. The ceiling in resident room A-7 contained a large brown stain.</p> <p>6. The faucet in resident room A-10 was observed to have a continuous drip.</p> <p>7. The faucet and hot/cold knobs on the sink in resident bathroom B-3 were observed to be loose.</p> <p>8. The speaker/call bell reset plate was observed to be loose in resident rooms A-2 and B-1.</p> <p>9. The personal call bell plate was loose in resident room B-1.</p> <p>10. The string to activate the overbed light in resident room A-2 was not long enough for the resident to reach.</p> <p>11. The wood frame around the attic access was observed to be loose in resident bathroom B-5.</p> <p>Interview on September 29, 2010, at 1:05 p.m., with the Maintenance Supervisor (MS) revealed staff was required to fill out a work order for any items in need of repair. The MS stated the MS made rounds every day to detect items in need of repair but had failed to identify the items listed.</p>	F 465	reviewed by the QA committee.	10/29/10
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIB LE</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</p>	F 514	<p>As noted, the resident initially claimed not to have any allergies, the verbal report from the nursing home that the resident came from was that she does not have any drug allergies and a check of her records at the doctor's office indicates that they have no record of any allergies. The face sheet from the previous nursing home indicates no allergies. Some of the MAR's from the other nursing home indicates</p>	

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F 514	<p>Continued From page 18</p> <p>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, and record review, it was determined the facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices for one (1) of seventeen (17) residents (resident #11).</p> <p>The findings include:</p> <p>Review of the medical record revealed resident #11 was admitted to the facility on September 21, 2010, with diagnoses of Status Post Open Reduction with Internal Fixation of the Femur Neck, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Depression. Further review revealed resident #11 had been transferred from another long-term care facility. A Comprehensive Assessment Minimum Data Set (MDS) had not been completed as the resident had been in the facility for eight days. Review of the nurse's notes dated September 21, 2010, revealed resident #11 was alert and oriented.</p> <p>Further review of the medical record revealed staff had recorded that resident #11 had no known allergies on the inside cover of the medical record, in the admission nurse's notes, on the physician order sheet, and on the MAR. Review of the MAR and immunization record provided by the transferring facility revealed resident #11 was allergic to Dilantin (an anti-seizure medication).</p>	F 514	<p>that there are no allergies but there were some MAR's that initially had NKA on them but beside that Dilantin was written in. The record for the resident mentioned has been changed by the resident's nurse to reflect Dilantin as an allergy and a review of the resident's record on 10/22/10 confirmed that the change had been made. Records for all residents have been checked by the pharmacist on 10/20/10 to make sure that there are no inconsistencies. Upon admission a second nurse will review medication orders including whether there are any drug allergies to assure that no allergies are missed. The pharmacist will review all resident records each month for any inconsistencies related the drug allergies. Results of this review will be reviewed by the QA committee.</p>	10/29/10

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F 514	<p>Continued From page 19</p> <p>Interview on September 29, 2010, at 12:30 p.m., with resident #11 revealed the resident had an allergic reaction to Dilantin approximately seven years ago. Resident #11 stated the resident had a stroke and was given Dilantin which caused a severe rash.</p> <p>Interview on September 29, 2010, at 1:20 p.m., with LPN #3 revealed LPN #3 admitted resident #11 to the facility on September 21, 2010. LPN #3 stated resident #11 told the LPN the resident did not have any drug allergies. LPN #3 stated the transferring facility faxed the resident information; however, the LPN did not notice the allergy to Dilantin.</p> <p>Interview on September 29, 2010, at 1:50 p.m., with the Director of Nursing (DON) revealed staff was required to ask the resident regarding any allergies during admission; however, staff should verify the information with the family and should review any and all documentation sent with a resident.</p>	F 514		

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NAME OF PROVIDER OR SUPPLIER  <b>JACKSON MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>69 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402</b>
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K 000 INITIAL COMMENTS

K 000 *11/29/10 Rec + equ TO HO. (cont)*

42 CFR 483.70(a)

K3 BUILDING: 0101  
K6 PLAN APPROVAL: 1989  
K7 SURVEY UNDER: 2000 Existing  
K8 SNF/NF

Type of Structure: One story, Type V (111), protected wood combustible construction with a complete automatic (dry) sprinkler system and six smoke compartments.

*POC ALL*

A Comparative Federal Monitoring Survey was conducted on 11/04/10 following a State Agency Survey on 09/28/10, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Jackson Manor was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.

**DEC 13 2010**  
*W*

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).

K 066 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

K 066 The facility procedure was to place cigarette butts into a metal bucket and to pour water into said bucket before the butts were put into the dumpster eliminating any chance of fire from the materials.

Smoking regulations are adopted and include no less than the following provisions:

(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.

The facility will purchase a metal self closing container into which butts will be placed before they are placed with other combustible materials. No residents were affected by this practice since butts were safely disposed of but any resident could be

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>ChA. Kelley</i>	TITLE <i>Adm.</i>	(X6) DATE <i>11-29-10</i>
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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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K 066	<p>Continued From page 1</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide the outside smoking areas with metal containers equipped with a self-closing cover device into which ashtrays can be emptied. This deficient practice affected two of six smoke compartments, staff, and 15 residents. The facility has the capacity for 51 beds with a census of 48 the day of survey.</p> <p>Findings Include:</p> <p>Observation on 11/04/10 at 10:30 a.m. revealed that the designated outside smoking areas for staff, visitors, and residents at the rear of the facility and at the front entrance to the facility were not equipped with metal containers with self-closing covers into which ashtrays could be emptied to permit smoking materials to be completely extinguished prior to disposal with other combustible trash. Interview on 11/04/10 at 10:30 a.m. with the Maintenance Director</p>	K 066	<p>affected by this practice if hot butts were placed with combustible materials.</p> <p>Housekeeping/maintenance staff will be instructed to empty ash trays into metal containers with self closing lids and to leave these smoking materials in said bucket for at least 24 hours before they are emptied into trash containers with combustible materials. Environmental rounds will be done monthly by the maintenance director and the housekeeping supervisor and they will assure that the buckets are available for use.</p>	12/24/10
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**K 066** Continued From page 2  
revealed that the facility was not aware of the requirement for metal containers with a self-closing covers.

The census of 48 was verified by the Administrator on 11/04/10. The finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/04/10.

Actual NFPA Standard: NFPA 101 19.7.4 (3), (4). Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.

**K 066**

**K 154** NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F  
Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop and coordinate a documented procedure to evacuate the facility or initiate a fire watch and notify the authority having jurisdiction when the required automatic sprinkler system is out of service for more than four hours in a

**K 154** The facility had a fire watch procedure in place including a worksheet onto which information related to the fire watch were recorded. Both blank and completed forms were available on the day of the survey but the written policy could not be located.

The administrator has developed a written policy related to the fire watch procedure. No resident was affected since the fire watch procedure was followed but all residents could be affected if the procedure had not been followed.

The maintenance director will review the procedure each time the fire alarm or the sprinkler system is down and make sure that it is followed. After each event, the administrator will check the worksheet to

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**K 154** Continued From page 3  
24-hour period. The deficient practice affected all smoke compartments, staff, and all residents. The facility has the capacity for 51 beds with a census of 48 the day of survey.

**K 154**  
make sure that the proper procedure has been followed.

12/24/10

Findings include:  
On 11/04/10, at 11:30 a.m., during review of the facility Life Safety Code Policy and Procedures, the facility was unable to provide a documented procedure for evacuation of the facility or setting up an approved fire watch that included notification the authority having jurisdiction during periods when the automatic sprinkler system is out of service for more than four hours in a 24-hour period. Interview with the Administrator on 11/04/10 at 11:30 a.m. revealed that the facility was aware of the requirement to evacuate the building or set up a fire watch when the sprinkler system was not functional, but was not aware the procedure could not be found.  
The census of 48 was verified by the Administrator on 11/04/10. The finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/04/10.  
Actual NFPA Standard: NFPA 101, 9.7.6.1.  
Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.

**K 155** NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F  
Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is

**K 155** The facility had a fire watch procedure in place including a worksheet onto which information related to the fire watch were recorded. Both blank and completed forms were available on the day of

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K 155 Continued From page 4

provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop and coordinate a documented procedure to evacuate the facility or initiate a fire watch and notify the authority having jurisdiction when the required fire alarm system is out of service for more than four hours in a 24-hour period. The deficient practice affected all smoke compartments, staff, and all residents. The facility has the capacity for 51 beds with a census of 48 the day of survey.

Findings include:

On 11/04/10, at 11:30 a.m., during review of the facility Life Safety Code Policy and Procedures, the facility was unable to provide a documented procedure for evacuation of the facility or setting up an approved fire watch and notifying the authority having jurisdiction during periods when the fire alarm system is out of service for more than four hours in a 24-hour period. Interview with the Administrator on 11/04/10 at 11:30 a.m. revealed the facility was aware of the requirement to evacuate the building or set up a fire watch when the fire alarm system was not functional, but was not aware the procedure could not be found.

The census of 48 was verified by the Administrator on 11/04/10. The finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/04/10.

K 155

the survey but the written policy could not be located.

The administrator has developed a policy related to the fire watch procedure. No resident was affected since the fire watch procedure was followed but all residents could be affected if the procedure had not been followed.

The maintenance director will review the procedure each time the fire alarm or the sprinkler system is down and make sure that it is followed. After each event, the administrator will check the worksheet to make sure that the proper procedure has been followed.

12/24/10

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K 155 Continued From page 5  
Actual NFPA Standard: NFPA 101, 9.6.1.8.  
Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.

K 155