

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

PRINTED: 12/20/2013
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 _____		(X3) DATE SURVEY COMPLETED R 12/20/2013
NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS An offsite revisit was conducted and based on the acceptable POC the facility was deemed to be in compliance as alleged on 12/13/13.	{F 000}			

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

TITLE

(X6) DATE

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

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F 000	INITIAL COMMENTS	F 000	The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, comfortable, homelike environment as evidenced by water leaks in the day room as well as in resident room B1. The findings include: Observation, on 11/07/13 at 11:10 AM, revealed an area rug in the day room was saturated with a liquid. Further observation revealed standing water on the floor beneath the area rug. Continued observation revealed a clear liquid oozed and bubbled up from the floor (between each faux wood strip of linoleum) when staff and surveyors walked within approximately 12 feet from the wall which separated the day room from the adjacent mechanical room. Subsequent observation of the day room, on 11/07/13 at 2:55 PM, revealed standing water remained beneath the area rug.	F 252	The leak in the water pipe was repaired on 11-13-13. Prior to the final repair the following actions were taken to ensure the safety of the residents. On 11-4-13 materials were placed around the leak to absorb as much water as possible. A carpet cleaner was used to remove any water that seeped into the carpet and a fan was used to assist in drying. The rug in the TV lounge was moved and the furniture rearranged to limit access to the damp area. A floor dryer fan was also used to maintain dryness. The facility Maintenance Director has monitored the building daily and the Weekend Supervisor has monitored the building on the weekends since 11-7-13 and no other leaks have been noted. The Maintenance Director will make environmental rounds weekly beginning 12-2-13 and will check specifically for any leaks. Facility staff		

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

Ph.D. Sullivan

TITLE

Adm

(X6) DATE

12-13-13

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F 252	Continued From page 1 Observation, on 11/07/13 at approximately 11:35 AM, revealed the carpet in resident room B1 appeared to be wet. An industrial type fan was in use and aimed toward the wet area. Subsequent observation of resident room B1, on 11/07/13 at 3:00 PM, revealed a floor dryer fan remained in use and was slowly drying the carpeted floor of resident room B1. Interview with the Maintenance Director, on 11/07/13 at 3:02 PM, revealed there had been issues with water leaks, as the pipes were old and when repairs were made it would trigger a leak in another area. The Maintenance Director stated he had not been aware of the leak in the dayroom until earlier in the day on 11/07/13, and he had made arrangements for repairs to be done on Monday 11/11/13. Continued interview revealed resident room B1, also adjacent to the dayroom, had a leak on Monday 11/04/13, which was also in the process of being repaired. The Maintenance Director stated he was not aware of any offer to have the resident moved to another room while the repairs were completed. Interview with the Director of Nursing (DON), on 11/07/13 at 7:44 PM, revealed she was not aware of the leak in the dayroom. Interview with the Administrator, on 11/07/13 at 8:28 PM, revealed he didn't believe the leak in the dayroom was a fall hazard, as the tiles were slip resistant and unlikely to contribute to a resident fall. Continued interview revealed residents could be affected by the growth of mold if the standing water was present long enough.	F 252	were re-educated on the procedure to report any maintenance issues including any noted water leaks on 12/13/13 by the administrator. A written memo was also placed in the employee break room on 12/02/13 regarding this procedure. The Regional Director of Facility Maintenance to review monthly any water leak reports to ensure they have been addressed timely and appropriately. All water leaks will be reported to the Administrator and the Administrator will report any ongoing or repeated problems to the facility QA committee no less than quarterly for at least one year.	12/13/13	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	<p>Continued From page 2</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 review of facility policy, it was determined the facility failed to ensure the resident environment remained free of accident hazards. Observation on 11/06/13 revealed the facility beauty shop door was not secure. Continued observation revealed the presence of accessible and potentially dangerous items including scissors, crochet-style hooks, and hazardous chemicals. In addition, standing water was observed in the resident day room.</p> <p>The findings include:</p> <p>(1) Review of the facility's Chemical Safety and Storage policy, not dated, revealed chemicals that are hazardous are stored in a secure area.</p> <p>Observation, on 11/06/13 at 4:32 PM, revealed the beauty shop door was not locked. Continued observation revealed two (2) pair of scissors and three (3) crochet-style hooks (used to pull hair through a cap during the hair coloring process) were in an unlocked drawer. Additionally, a one (1) gallon container of McKesson Apricot Shampoo and Body Wash and one (1) glass jar containing a blue liquid, and labeled Barbicide, was on the counter. Barbicide is a chemical</p>	F 323	<p>The unlocked door was fixed on 11-6-13 and now remains locked at all times. A sign was placed on the door to remind staff that the door is to remain closed and locked at all times. Maintenance Director checked all other doors to areas that may pose a risk for residents to ensure that all doors were locked. This was completed on 11-6-13.</p> <p>The Maintenance Director will make environmental rounds weekly beginning 12-2-13 and will check for any safety issues including but not limited to locked doors, alarm systems, storage of chemicals, leaks, etc. These environmental rounds are recorded in TELS and are reported to the facility safety committee monthly. Any issue found will be addressed immediately.</p> <p>Facility staff were re-educated on the procedure to report any maintenance issues including any noted water leaks on 12/13/13 by the administrator, any employee who misses this meeting will be required to attend makeup meeting as soon as possible. A written memo was also placed in the employee break room regarding this procedure on 12/02/13.</p>

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F 323	<p>Continued From page 3</p> <p>solution used for sanitizing brushes and combs.</p> <p>Further observation revealed one (1) of seven (7) residents assessed by the facility to be a wander risk was present in the vicinity of the beauty shop at the time the door was found to be unsecured.</p> <p>Review of the Material Safety Data Sheet (MSDS) for the McKesson Apricot Shampoo and Body Wash revealed the product could cause eye irritation with prolonged exposure, as well as possible gastrointestinal irritation or disturbance if swallowed.</p> <p>Review of the MSDS for the Barbicide revealed it to be a corrosive agent capable of causing irreversible eye damage or skin burns, with the potential for death if swallowed.</p> <p>Interview with the facility Beautician, on 11/07/13 at 11:24 AM, revealed the door to the beauty shop should be locked, and scissors and hooks were normally kept in a locked drawer within the beauty shop. The Beautician stated she did not know if Barbicide was harmful to residents, but believed it could make them sick.</p> <p>Interview with the Administrator, on 11/07/13 at 8:28 PM, revealed he felt there was a "slight possibility" of residents getting in and injuring themselves if the door was unlocked and hazardous items were unsecured inside the beauty shop. The Administrator stated the door could not be opened easily, and he did not believe any of the residents identified as wander risks would go through a closed door; however, he acknowledged the possibility existed.</p> <p>(2) Observation, on 11/07/13 at 11:10 AM,</p>			F 323	<p>Maintenance Director to report finding of weekly rounds to Administrator and Administrator to report on any and all findings related to the environmental rounds and findings of the Safety Committee to the Facility QA Committee no less than quarterly for one year.</p> <p>The leak in the water pipe was repaired on 11-13-13. Prior to the final repair the following actions were taken to ensure the safety of the residents. On 11-4-13 materials were placed around the leak to absorb as much water as possible. A carpet cleaner was used to remove any water that seeped into the carpet and a fan was used to assist in drying. The rug in the TV lounge was moved and the furniture rearranged to limit access to the damp area. A floor dryer fan was also used to maintain dryness.</p> <p>The facility Maintenance Director has monitored the building daily and the Weekend Supervisor has monitored the building on the weekends since 11-7-13 and no other leaks have been noted.</p> <p>The Maintenance Director will make environmental rounds weekly beginning 12-2-13 and will check specifically for any leaks. Facility staff</p>		

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F 323	<p>Continued From page 4</p> <p>revealed an area rug in the day room was saturated with a liquid. Further observation revealed the floor under the area rug was saturated with a clear liquid. Continued observation revealed a clear liquid oozed and bubbled up from the floor (between each faux wood strip of linoleum) when staff and surveyors walked within approximately 12 feet from the wall of the adjacent mechanical room. Continued observation revealed three (3) residents were present in the day room, sitting in their wheelchairs.</p> <p>Observation, on 11/07/13 at approximately 11:35 AM, revealed the carpet in resident room B1 appeared to be wet and an industrial type fan was in use and aimed towards the wet area. The resident was not in his/her room at the time of the observation.</p> <p>Observation, on 11/07/13 at 2:55 PM, revealed standing water remained present in the day room. Although the source of the water could not be determined, walking on the tile floor of the dayroom caused water to seep up between the tiles. An area rug with a rubberized bottom covered a large area of the leak, with standing water evident when the area rug was pulled up.</p> <p>Interview with the Maintenance Director, on 11/07/13 at 3:02 PM, revealed he became aware of a leak in room B1 on Monday (11/04/13), and had been in the process of drying out resident room B1 while attempting to find the leak. The Maintenance Director revealed he was not aware of the water leak in the day room until 11/07/13. He stated there was the possibility a resident could fall as a result of the standing water in the floor.</p>	F 323	<p>were re-educated on the procedure to report any maintenance issues including any noted water leaks on 12/13/13 by the administrator. A written memo was also placed in the employee break room on 12/02/13 regarding this procedure. The Regional Director of Facility Maintenance to review monthly any water leak reports to ensure they have been addressed timely and appropriately. All water leaks will be reported to the Administrator and the Administrator will report any ongoing or repeated problems to the facility QA committee no less than quarterly for at least one year.</p>	12/13/13
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F 371	<p>Continued From page 6</p> <p>on 11/06/13 revealed an open bag of wheat bread with a white substance on the crust of ten (10) slices, one (1) half-pint carton of chocolate milk with an expiration date of 11/02/13 in the refrigerator, and three (3) cooked sweet potatoes in an undated and unlabelled plastic bag in the refrigerator.</p> <p>The findings include:</p> <p>During a tour of the nourishment room with the Director of Nursing (DON), on 11/06/13 at 4:50 PM, ten (10) slices of wheat bread, with a white substance on the crust, were observed in an open bag on the counter. Continued observation revealed one (1) half-pint carton of chocolate milk, with a manufacturer's expiration date of 11/02/13, was stored in the refrigerator. Further observation revealed an unlabelled and undated plastic bag containing three (3) cooked sweet potatoes.</p> <p>Interview with the DON, on 11/06/13 at 5:05 PM, revealed all food and fluids in the refrigerator should be dated and labelled and should not be available for resident consumption if past the expiration date. Further interview revealed molded bread should not be available for resident consumption. Continued interview revealed the Dietary Department was responsible for ensuring all outdated food and fluids were removed from the area.</p> <p>Interview with the Dietary Manager, on 11/06/13 at 5:10 PM, revealed the dietary department was responsible for ensuring outdated foods and fluids were not available for resident use. She stated the wheat bread was not the brand used by the facility; however, someone could have</p>	F 371	<p>weekly to ensure all items are dated appropriately and that all outdated foods are discarded. She will complete the inspections for 3 months then it will be completed monthly. The Dietary Director is to report any ongoing problems to the facility QA committee no less than quarterly for one year.</p>	11/15/13

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F 371 Continued From page 7 brought the bread in from outside the facility.

Interview with the Administrator, on 11/06/13 at 5:30 PM, revealed the outdated milk and molded bread should not have been available for resident use. Further interview revealed the plastic bag of sweet potatoes should have been labelled and dated prior to placement in the refrigerator. He stated the dietary department was responsible for ensuring expired foods and fluids were not available for resident use.

F 371

F 441 SS=D 483.65 INFECTION CONTROL, PREVENT 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 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if

F 441 All soiled feeding pumps and stands were cleaned on 11-6-13.
All feeding pumps and poles were checked by DON on 11-6-13 to ensure all pumps and poles in storage and in use were clean.
On a go forward basis the pumps and poles in use will be cleaned on a weekly basis by the third shift nursing staff. The third shift staff were educated on their responsibility on 12/13/13 by the administrator. Any new employee to third shift will be oriented to their responsibility by the nursing supervisor on third shift. All pumps and poles will be cleaned and disinfected when taken out of use. Once the pump has been cleaned and disinfected it will be covered with plastic and stored in the nourishment room. Housekeeping staff will be

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F 441	<p>Continued From page 8</p> <p>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 and interview, it was determined the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection. Observation revealed the presence of three (3) soiled tube feeding infusion pumps and two (2) soiled infusion pump mounting poles in the nutrition room.</p> <p>The findings include:</p> <p>During tour of the nutrition room with the Director of Nursing (DON), on 11/06/13 at 4:50 PM, three (3) soiled tube feeding infusion pumps and two (2) soiled infusion pump mounting poles were observed to be stored in the clean area.</p> <p>Interview with the DON, on 11/06/13 at 5:05 PM, revealed equipment was to be stored in the nutrition room after being cleaned, which ensured only clean equipment was available for resident use. She stated it was an infection control issue for soiled equipment to be stored in the nutrition room.</p>	F 441	<p>responsible for this procedure and housekeeping staff were educated on their responsibility by the administrator on 11/12/13. All newly hired housekeeping staff will be educated on this procedure during orientation by the Housekeeping Director. The Director of Nursing and Housekeeping Director are to report any ongoing problems to the facility QA Committee no less than quarterly for one year.</p>	12/13/13

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F 441	Continued From page 9 Subsequent interview with the DON, on 11/06/13 at 5:25 PM, revealed the housekeeping department was responsible for cleaning the equipment. However, she was unable to locate or provide a facility policy related to the cleaning and storage of equipment. Interview with the Administrator, on 11/06/13 at 5:30 PM, revealed soiled equipment should not have been in the nutrition room. He stated only clean equipment was to be stored in that room so staff would know the equipment was ready for resident use. Continued interview revealed housekeeping was supposed to clean the equipment prior to placing it in the nutrition room.	F 441			

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NAME OF PROVIDER OR SUPPLIER JACKSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444, P O BOX 194 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1989</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (III)</p> <p>SMOKE COMPARTMENTS: 5</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 11/07/13, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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