

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

R E C E I V E D

JUN 27 2013

PRINTED: 06/18/2013
FORM APPROVED
OMB NO. 0938-0391
06/04/2013

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 C 06/04/2013
NAME OF PROVIDER OR SUPPLIER JACKSON MANOR		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 abbreviated standard survey (KY20223) was conducted on 06/04/13. The complaint was substantiated with deficient practice identified at "D" level.	F 000	The preparation and execution of this Plan of Correction does not constitute an admission or agreement by Jackson Manor Health and Rehabilitation of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency.	
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, review of the facility's policy, and review of the letter sent to the resident's responsible party, it was determined the facility failed to ensure a physician documented in the resident's medical record that the discharge was necessary for the resident's welfare and/or that the resident's needs could not be met by the facility, for one of three sampled residents (Resident #1). The findings include: Review of the facility's policy entitled "Discharge Planning," created on 03/22/07, revealed the intent of the policy was to ensure appropriate discharge planning and communication of	F 202	This Plan of Correction is prepared and executed solely because it is required by Federal and State law. 1) Resident # one is currently a resident of the facility and there are no plans for discharge at this time. The resident's physician has documented the resident's behaviors upon his visit on 6/11/13. 2) When a resident is identified as being a danger to self or others or if their condition has improved to a point that they do not require Nursing Facility care or if they fail to pay for their stay after reasonable and appropriate notice then they would be identified as at risk for this alleged deficient practice. The administrator and the social services director met on 6/22/13 at 9 a.m. and reviewed all residents and found that no resident met this criteria, any other	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Adm.* (X6) DATE: 6-27-13

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 202	<p>Continued From page 1</p> <p>necessary information to the continuing care provider. The policy stated the Social Services Director (SSD) was the staff member designated as the person responsible for discharge planning.</p> <p>Interview on 06/04/13, at 3:15 PM, with the Director of Nursing (DON) revealed the above-mentioned facility policy was the only policy addressing discharge of a resident from the facility.</p> <p>Review of the facility letter sent to Resident #1's Power of Attorney (POA) on 05/09/13, revealed the resident would be discharged from the facility to protect staff and other residents on or before 06/09/13.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 04/26/13, following a hospital stay. The record revealed the resident had diagnoses of Alzheimer's Disease, Dementia, Hypothyroidism, Chronic Anemia, Failure to Thrive, Chronic Diarrhea, and Diabetes.</p> <p>Review of Resident #1's nurse's notes revealed on 04/28/13, at 11:00 AM, the resident's bed alarm sounded and the resident had gotten in bed with the roommate. The review of the nurse's notes revealed Resident #1's behaviors consisted of attempting to eat paper products, wandering into other residents' rooms and messing with their oxygen, crawling on the floor, climbing out of a Geri-chair under the lap tray, climbing on furniture, pushing over a pedestal which broke a vase, licking his/her own hands, and playing in the resident's own feces. The review revealed the resident's behaviors continued to escalate and staff notified the resident's physician and</p>	F 202	<p>Discharge notice issues were also reviewed over the past year and there are none so we found that no other resident was affected.</p> <p>3) Administrator, SSD and DON reviewed the discharge criteria to ensure all were aware of criteria for a discharge notice and related documentation to support the need for discharge. All voiced understanding. This was completed on 6/27/13. Regional Director of Operations will be consulted prior to the issuance of any discharge notice beginning 6/27/13.</p> <p>4) Corporate consultant to review all Notice of Discharge and supporting documentation no less than quarterly for one year and will report any findings to the facility QA committee for review.</p> <p>5)</p>	6/27/13	

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F 202	Continued From page 2 POA on multiple occasions. Review of Resident #1's Social Services Progress Notes revealed on 05/03/13, at 9:15 AM, staff felt the resident's hearing was impaired and vision was highly impaired. The note revealed the resident propelled him/herself in a wheelchair or crawled on the floor at times, attempted to ingest non-food items such as paper products, wandered in the lobby and other resident rooms, and scratched staff, so the resident was added to the facility's Behavioral Management Program. The review revealed on 05/08/13, at 8:15 AM, Resident #1 experienced an increase in agitation, wandered up/down halls and in/out of other residents' rooms, and rummaged through other residents' belongings. The note further stated the resident displayed aggressive behaviors (grabbing, pinching, and spitting) towards staff when redirected and staff had notified the primary physician and the psychiatrist. A note dated 05/09/13, at 10:00 AM, revealed the Assistant Director of Nursing (ADON), a floor nurse, the Minimum Data Set (MDS) Coordinator, the SSD, and the Administrator held a meeting to discuss Resident #1's behaviors, the increase in the resident's behaviors, and the safety of the other residents. The staff felt the resident would be better managed in another facility which was equipped to provide one to one (1:1) supervision. Therefore, it was decided the Administrator would issue a 30-day discharge letter to be mailed to the POA. Further review revealed on 05/09/13, at 10:55 AM, the daughter was notified by the SSD of the need for alternate placement for Resident #1. The review revealed the resident's behaviors had continued to escalate throughout the resident's stay.	F 202			

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F 202	<p>Continued From page 3</p> <p>Review of the physician's progress notes, physician's orders, and the consultation notes revealed no documented evidence by a physician that discharge was necessary for Resident #1's welfare and/or that the resident's needs could not be met by the facility.</p> <p>Observation on 06/04/13, at 11:30 AM, revealed Resident #1 in a wheelchair in the dining room with staff awaiting the lunch tray, and at 12:40 PM staff was propelling the resident throughout the facility. Further observations on 06/04/13, at 1:20 PM revealed Resident #1 at the nurses' station attempting to stand up and the alarm sounding.</p> <p>Interview on 06/04/13, at 3:15 PM with the SSD revealed due to Resident #1's behaviors, the resident required 1:1 supervision for the safety of Resident #1 and the other residents. The SSD stated after nursing staff notified her that Resident #1 was in the room of one of the tracheostomy residents and knowing Resident #1's history of pulling at oxygen tubing of the other residents, it was apparent that the safety of the other residents was an immediate concern. The interview revealed on 05/09/13, the SSD held a meeting with the Administrator, MDS Coordinator, and a floor nurse to discuss Resident #1's behaviors and the safety of the other residents. The decision was made that Resident #1 required more care than the facility was able to provide. According to the SSD, the Administrator made the final decision and wrote the 30-day discharge letter which was mailed that same day to the POA. The SSD stated the Administrator was the staff member responsible for Resident #1's discharge process. The SSD</p>	F 202			

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F 202	Continued From page 4 was unaware of the requirement for a physician's documentation of the need for discharge and confirmed there was no physician documentation. The interview revealed the SSD had not in the two years as SSD attempted to discharge a resident due to the facility being unable to meet the resident's needs. Interview on 06/04/13, at 3:15 PM with the DON revealed the Administrator was on vacation the week of 06/03-10/13. According to the DON, she was not working on 05/09/13, when the meeting was held regarding Resident #1's behaviors/discharge. The DON stated she was unaware of the discharge letter being sent until the weekend of 06/01-02/13, when the POA informed facility staff that the POA had won the appeal and the discharge for Resident #1 was cancelled for 06/09/13.	F 202			