

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

PRINTED: 10/27/2015
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 R 10/27/2015
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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 An offsite revisit survey was conducted, and based on the acceptable Plan of Correction, the facility was deemed to be in compliance on 10/19/15 as alleged.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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F 000 INITIAL COMMENTS

A Standard Recertification Survey was initiated on 09/22/15 and concluded on 09/24/15. Deficiencies were cited with the highest Scope and Severity of a "F".

F 282 : 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=D

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 by qualified persons in accordance with each residents written plan of care for one (1) of nineteen (19) sampled residents (Resident #9). Observation on 09/23/15, revealed staff did not provide care as outlined by the Comprehensive Care Plan for Resident #9 as evidenced by the failure to place Geri-Sleeves on the resident's arms and failure to provide oral care and denture care.

The findings include:

Interview with the Administrator, on 09/23/15 at 3:45 PM, revealed the facility did not have a policy related to ensuring staff followed residents' Comprehensive Care Plan interventions. However, the Administrator stated it was the responsibility of all staff to ensure each resident's

F 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.

F 282 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.

F282
SRNA #3 was educated by the Staff Facilitator on 10/14/2015, regarding following all the care plan interventions including skin protection and oral care for residents.

Resident #9 received oral care and had geri-sleeves placed on her arms on 9/23/15.

27 2015

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

[Handwritten Signature]

TITLE

[Handwritten Title: Admin]

(X6) DATE

10/27/15

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F 282 Continued From page 1
care plan interventions were followed.

Review of Resident #9's medical record revealed the facility admitted the resident on 03/22/2012 with diagnoses which included; Fracture of the Femur, Dementia without Behavioral Disturbance, Atrial Fibrillation, Congestive Heart Failure, Urinary Tract Infection, and Escherichia Coli. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/21/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15) indicating the resident was severely cognitively impaired. Further review, revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for bed mobility, transfers, dressing, toileting, and personal hygiene.

Review of the Comprehensive Care Plan, dated 07/30/15 revealed, the resident had the potential for skin impairment with the goal stating the resident would not experience development of skin integrity impairment. There were several interventions including Geri-Sleeves for arm protection. Further review of the the Comprehensive Care Plan dated 07/30/15, revealed the resident had a care deficit pertaining to the teeth or oral cavity. The goal stated the resident would be able to chew and swallow food sufficiently. The interventions included providing oral hygiene and denture care.

Observation of personal hygiene care on 09/23/15 at 9:30 AM, revealed, Certified Nurse

F 282 All residents have the potential to be affected by the failure of staff to provide care according to the written plan of care. To identify other residents, rounds to all resident rooms, to observe care being provided, were completed by the Administrative Nursing Team including the Assistant Director of Nurses (ADON), the Quality Improvement (QI) Nurse, the MDS Nurses, the Staff Facilitator, and the Treatment Nurse, 09/25/2015 through 9/30/2015, 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 Administrator, Staff Facilitator, and/or QI Nurse, 10/15/2015 -10/18/2015, regarding referring to the plan of care prior to providing care to any resident. Agency staff and new employees will receive this education as a part of orientation.

To monitor the effectiveness of this education and ensure continued compliance with providing care in accordance with the written plan of care,

10/19/15

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F 282 Continued From page 2

Aide (CNA) #3 who was assigned to the resident, did not put Geri-Sleeves on Resident #9, nor did the CNA provide oral hygiene, and assist with or provide denture care after performing personal hygiene care as outlined by the Comprehensive Care Plan.

Interview on 09/23/15 at 9:45 AM, with CNA #3 revealed, Resident #9 removed the Geri-Sleeves off when the CNA's put them on; however, CNA#3 stated she had not reported this to the nurse on duty. CNA #3 stated, she should have reported to the nurse, Resident #9 refused to wear the Geri-Sleeves so the Care Plan could be updated. Further interview, revealed CNA #3 forgot to perform oral hygiene and denture care. CNA #3 stated oral hygiene and denture care should have been provided as outlined by the Comprehensive Care Plan.

Interview on 09/23/15 at 3:30 PM, with the Director of Nursing (DON), revealed her expectation was for staff to follow resident care plans when providing care, and to report any changes in care to the nurse immediately, so the care plan could be updated accordingly.

Interview on 09/23/15 at 3:45 PM, with the Administrator, revealed it was her expectation for all staff to provide care based on the resident's care plan. If care was not provided, it should be reported to the nurse so the appropriate changes could be made, or an investigation could be done to determine why the care was not being provided.

F 282 the Administrative Nursing Team, including the Director of Nurses, Assistant Director of Nurses, QI Nurse, MDS Nurses and Staff Facilitator will audit 5% of the total resident population, three time per week, through direct observation of the resident as compared to the care plan. These audits will continue for twelve months. Findings will be documented on the Nursing Rounds Quality Improvement 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 x 3. The results of these weekly/monthly QI meeting will be reported to the quarterly 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 363 Continued From page 3
F 363 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's Tray Tickets, it was determined the facility failed to ensure the menu was followed for three (3) of nineteen (19) sampled residents, (Residents #5, #8, and #13) and two (2) unsampled residents (Unsampled Resident A and B). Observations of the noon and evening meal on 09/22/15, revealed Resident #5, #8, #13, and Unsampled Resident A, and B received food items listed as "dislikes" on their lunch and dinner tray.

The findings include:

Review of the facility policy titled "Initial Resident Visitation", dated August 2013, revealed the purpose of the policy was to assure the Dietary Department was aware of resident's likes and dislikes and eating habits and patterns. New residents were visited by the Dietary Manager or Assistant prior to completing the Resident Assessment. If the resident was unable to communicate, the resident's family would be contacted to determine the resident's likes and dislikes. The Dietary Manager was to complete a questionnaire and from this information and

F 363F363
F 363 Dietary provided replacements for the dislikes served to residents for whom they were timely made aware of having served, dislikes or failed to include all routine drinks, including Resident #5.

All residents have the potential to be served food that has been identified as a dislike or fail to receive all routine drinks for each meal. The Dietary Manager viewed the plating of all food and drinks for all three meals, on 9/24/2015 and 9/25/2015, to ensure all residents were served food appropriately per their likes and dislikes. In addition, she visited Residents' Council, on 9/30/2015, and asked all present whether they had received foods they had identified as dislikes or failed to receive all their drinks as desired. No additional residents voiced concerns.

The Dietary Manager educated all Dietary staff that resident tray cards will be checked by the Cook for diets, dietary likes/dislikes prior to plating each resident's food. A second check of each resident tray will be completed by the Dietary Aide prior to the tray being placed on the food delivery cart to ensure the food being served is correct per the tray card. This education was

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F 363 Continued From page 4

Physician's orders, a tray card would be made for the resident which included the resident's diet, dislikes, beverage preference, and any special requests were listed on the card.

1. Review of Unsampld Resident A's medical record, revealed the facility admitted the resident on 08/19/15 with a diagnosis of Malignant Neoplasm of the Pancreas. Observation on 09/22/15 at 4:55 PM, revealed the resident was served green beans on the dinner meal tray. Further observation revealed Unsampld Resident A's Tray Ticket revealed "green beans" was listed as a dislike on the meal card.
2. Review of Unsampld Resident B's medical record, revealed the facility admitted the resident on 12/26/11 with diagnoses with a diagnosis of Dementia with Behavioral Disturbance. Observation on 09/22/15 at 11:40 AM, revealed Unsampld Resident B was served Salisbury Steak for the noon meal. Further observation revealed Unsampld Resident B's Tray Ticket revealed "Salisbury Steak" was listed as a dislike on the meal card.
3. Review of Resident #8's medical record revealed the facility admitted the resident on 08/25/14, with diagnoses including Lewy Body Syndrome, Coronary Artery Disease, Dementia, Psychosis, and Depressive Disorder. Review of the Annual Minimum Data Set (MDS) Assessment dated 07/20/15, revealed the facility assessed the resident as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) of a four (4) out of fifteen (15). Review of Resident #8's Tray Ticket for the evening meal on 09/22/15, revealed "cauliflower" was listed on his/her list of dislikes.

F 363 done 10/13/2015 – 10/18/2015. This education will be provided to all new dietary hires and agency staff as a part of orientation.

All staff who provide care to residents including licensed nurses, nursing assistants, activities staff, social services and dietary were educated by the Administrator, Staff Facilitator, and/or QI Nurse, 10/15/2015 -10/18/2015, regarding the need to check the food being served against the resident tray card at the time the tray is presented to the resident for serving of food. Should any discrepancy be noted the tray should be returned to the kitchen immediately for correction prior to being served. This education will be provided to all new hires and agency staff as a part of orientation.

To monitor the effectiveness of this education and ensure continued compliance with serving meals in accordance with resident preferences, the Dietary Manager or her designee will observe the food served to 5% of the residents daily, Monday-Friday, for four weeks, then 5% of residents for each meal three times per week for four (4) weeks followed by weekly observation of 5% of residents thereafter for 3 months,

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F 363 Continued From page 5

Observation of the evening meal service revealed Resident #8 was served his/her meal at 5:25 PM on 09/22/15, which included cauliflower.

4. Review of Resident #13's medical record revealed the facility admitted the resident on 06/16/15, with diagnoses including Pneumonia, Peripheral Vascular Disease, Bronchitis, and Disorder of Kidney and Ureter. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/10/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a fifteen (15) out of fifteen (15) indicating the resident was cognitively intact. Review of Resident #13's Tray Ticket for the evening meal on 09/22/15 specified "milk" on the routine liquids list.

Observation of the evening meal service revealed Resident #13 was served his/her meal at 5:25 PM on 09/22/15, and there was no milk on her/his meal tray.

5. Review of Resident #5's medical record revealed the resident was admitted to the facility on 11/12/13 with diagnoses including Alzheimer's Dementia with Behaviors, and Mood Disorder. The facility assessed Resident #5, in a Quarterly Minimum Data Set (MDS) Assessment dated 08/03/15, as severely cognitively impaired. Review of Resident #5's Tray Ticket for the evening meal on 09/22/15, revealed "green veggies" were listed on his/her list of dislikes.

Observation of the evening meal service revealed Resident #5 was served his/her meal at 5:25 PM on 09/22/15, which included green beans.

F 363 to observe the food served to those residents and observance of their likes and dislikes.

The results of these rounds will be reported at the weekly QI meeting for four (4) weeks; then monthly x 3. The results of these weekly/monthly QI meeting will be reported to the quarterly 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 363 Continued From page 6 F 363

Interview with Certified Nursing Assistant (CNA) #2, on 09/24/15 at 4:28 PM revealed, in serving trays, she ensured everything on the tray matched the tray ticket, with no dislikes served. If it didn't, CNA #2 revealed she would report back to dietary and get the matter corrected to ensure residents were served the correct diet. CNA #2 went on to state, in the past three (3) to four (4) months she had not observed any food dislikes served to residents

Interview with CNA #4, on 09/24/15 at 4:36 PM, revealed when serving meals to residents, she checked the tray ticket to ensure what was served matched the tray ticket. CNA #4 revealed, if she noticed a resident was served a dislike, she would take it back to the kitchen and have dietary prepare a new tray for the resident. CNA #4 went on to reveal she had not observed any errors with residents being served dislikes in the past three (3) to four (4) months.

Interview with CNA #5, on 09/24/15 at 4:43 PM, revealed she checked trays for accuracy against the tray tickets with each meal when serving residents. CNA #5 revealed she had noted and corrected maybe one (1) tray a month served with resident dislikes.

Interview with Cook #1, on 09/24/15 at 4:47 PM, revealed she placed resident food items on plates on the tray line. She stated, prior to her plating the food, a person before her calls out what is on a resident's tray ticket, and the person adding the drinks to the tray is a third check against the tray ticket to ensure meals were correct coming out of the kitchen. When the surveyor revealed dislikes had been served to five (5) different residents across lunch and dinner meal services on

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F 363 Continued From page 7
09/22/15, Cook #1 stated they would have to watch what they were doing more closely.

Interview with the Dietary Manager, on 09/24/15 at 5:02 PM, revealed during tray line for meals, the salad person looked at the tray ticket first, followed by the cook, and finally followed by the drink server. The Dietary Manager stated the nurse aide serving the meal should be a final check before the tray was given to the resident. The Dietary Manager revealed there was usually not a problem with staff serving dislikes by mistake, although she did reveal two (2) trays were returned to the kitchen on 09/22/15 for that reason. In addition to dislikes, the Dietary Manager stated allergies were also listed on resident tray tickets. The Dietary Manager revealed, if dislikes were served, the resident may end up not eating, which could eventually lead to weight loss. Further interview, revealed, the importance of paying attention to tray tickets was stressed with dietary staff because not doing so could pose a danger for residents with allergies.

Interview with the Administrator, on 09/23/15 at 3:05 PM, revealed her expectation regarding tray tickets was for residents to be served their preferences, and if for some reason the kitchen didn't catch a mistake, the person serving the food would. Regarding five (5) residents being served dislikes on 09/22/15 during lunch and dinner meals, the Administrator revealed, "someone isn't doing what they're supposed to, which needs to be investigated".

F 371 483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
SS=F

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F 371 Continued From page 8

- The facility must -
- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
 - (2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and review of facility's policy it was determined the facility failed to store, prepare, and serve food in a sanitary manner. Observation of the kitchen and dry storage area during survey revealed an accumulation of dust like particles over food preparation and service areas. Also, one (1) out of two (2) tested red sanitizer buckets did not contain sanitizer.

The findings include:

Review of facility policy titled "Sanitation Bucket Policy" undated, revealed the red sanitation buckets were to be changed every four (4) hours and refilled with sanitizer. Further review, revealed the cooks were responsible to check and record the amount of sanitizer in the red bucket.

Review of the "Dietary Sanitation Log" for the pot and pan sink, dated September 2015, revealed the sink sanitizer was being tested and recorded four (4) times daily. However, there was no

F 371

F371
Bucket #1 was emptied and filled with the appropriate sanitizer immediately after being tested and found deficient. The kitchen ceilings, vents, lights, loud speaker, cook's pot and pan rack, heater and piping in the dry storage area were dusted and cleaned on 9/23/2015.

All residents have the potential to be affected by conditions in Dietary.

The Dietary Manager has revised the weekly cleaning lists to include the heater and air vent in the dry storage; in addition, the night shift have been assigned the responsibility to dust the ceiling and anything attached to or hanging from the ceiling including pipes, cooks rack, cook's pot and pan rack, lights and/or speakers, three nights per week, Monday, Wednesday and Fridays. The Dietary Manager implemented a sanitation bucket test log to be completed with the level of sanitation in the bucket each time the sanitation buckets are filled for use. Dietary staff were educated by the Dietary Manager on each of these changes, 10/13/2015 - 10/18/2015. This education will be provided to all new dietary hires and agency staff as a part of orientation.

10/19/15

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

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FORM APPROVED
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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 09/24/2015
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)

F 371 Continued From page 9

documented evidence the red sanitizer buckets were checked and changed four (4) times daily.

Review of the "Dietary Cleaning Jobs" schedule dated September 2015, revealed the Cook's pot and pan rack was not listed to be cleaned.

Continued review of the schedule revealed air vents were to be cleaned every Friday; however, there was no documented evidence the air vents were cleaned on 09/18/15.

Observation on 09/22/16 at 9:55 AM, revealed an accumulation of dust like particles on the cooks rack over a food preparation table.

Observation on 09/22/15 at 10:00 AM, revealed two (2) red sanitizer buckets were tested and bucket #1 did not measure any sanitizer. Bucket #1 had been emptied and had a clear substance in the bottom of the bucket about one-fourth (1/4) inch deep. Red sanitizer bucket #2 was tested and contained the proper amount of sanitizer.

Observation on 09/22/15 at 10:05 AM, in the dry storage area revealed an accumulation of black dust like particles located on the ceiling, near an air vent and located above the dry storage over the can goods. Further observation revealed a heater suspended from the ceiling with an accumulation of black dust like particles, and there was also an accumulation of black dust like particles around the insulation on the pipes above the dry storage.

Observation on 09/22/15 at 4:10 PM, revealed an accumulation of dust like particles remained over the cooks rack.

Observation on 09/23/15 2:57 PM, revealed an

F 371 To monitor the effectiveness of this education and ensure continued compliance the Dietary Manager or in her absence the Cook, will check the sanitation buckets twice daily, for appropriate levels of sanitation. She will also survey the kitchen and storage areas daily, Monday through Friday, for cleanliness and to guard against dust accumulation on ceilings or items hanging from or attached to the ceiling. Any concerns identified during these checks will be addressed and corrected as indicated. This monitoring will become a permanent procedure in the Dietary Department.

The results of these checks will be reported at the weekly QI meeting for four (4) weeks; then monthly x3. The results of these weekly/monthly QI meeting will be reported to the quarterly 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.

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

PRINTED: 10/08/2015
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 09/24/2015
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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 371 Continued From page 10 F 371

accumulation of dust like particles over air vents, loud speaker, lights, above the resident tray line and over the food preparation areas in the kitchen.

Interview on 09/23/15 at 11:00 AM, with the Maintenance Manager, revealed Dietary was responsible for cleaning the air vents and cleaning around the heater in the dry storage.

Interview on 09/23/15 at 2:20 PM, with Dietary Aide/Cook #1, revealed there was a schedule for cleaning and everyone was assigned according to shift. Further interview, revealed all Dietary staff was responsible to clean their own area. The bucket sanitizer was to be changed three (3) times a day after meals and the sanitizer was to be checked when the bucket was changed.

Interview on 09/23/15 at 2:35 PM, with Dietary Aide #1, revealed there was assigned cleaning tasks each day and for each shift. Further interview, revealed the sanitizer was to be changed each shift and twice on night shift.

Interview on 09/23/15 at 2:40 PM, with Cook #1, revealed the cleaning list was posted and job duties varied. The bucket sanitizer was to be changed every four (4) hours and four (4) times a day. Further interview, revealed they used a check off sheet to record the pot and pan sink sanitizer.

Interview on 09/23/15 at 2:45 PM, with Cook #2, revealed she was assigned a weekly cleaning list but she sometimes forgot to initial when she had completed the task. Further interview revealed the sanitizer bucket was changed twice a day. The pot and pan sink was checked for sanitizer.

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

PRINTED: 10/08/2015
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 09/24/2015
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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F 371 Continued From page 11
and if the sanitizer was correct the bucket was correct.

Interview on 09/23/15 at 3:05 PM, with the Dietary Manager (DM), revealed she did not know Dietary was responsible for cleaning the heater in dry storage. She stated, Dietary was responsible for cleaning the air vents, lights in the dry storage, and air vents in the food preparation area. The DM stated the red sanitizer buckets were spot checked for sanitizer and the sanitizer log was for the pot and pan sink. She stated, the red sanitizer buckets were filled from the sanitizer in the pot and pan sink so the sanitizer should be accurate. She stated, if there was dust accumulation in the kitchen and the sanitizer was not at the correct level in the sanitizer buckets, this could cause cross contamination of food products.

Interview on 09/23/15 at 4:00 PM with the Administrator, revealed her expectations for Dietary was for foods to be prepared in a clean and sanitary manner.

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=E LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted

F 431 F431
All medication storage areas including medication/treatment carts, medication rooms and refrigerators were checked by the Administrative Nurse Team including the Director of Nurses, QI Nurse, SDC Nurse, MDS Nurses and Treatment Nurse on 9/24/2015, and all expired medications were removed from the storage areas.

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

PRINTED: 10/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2015
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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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F 431 Continued From page 12

professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's "Medication Expiration Dates Policy", it was determined the facility failed to ensure proper storage of drugs with current accepted professional principles as evidenced by expired medications stored in the North and South Medication Rooms.

The findings include:

F 431

All residents have the potential to be affected by expired medications.

The Assistant Director of Nurses was inserviced by the Director of Nurses on 9/28/2015, regarding her responsibility to properly check for and pull any expired medications located in the medication rooms or the refrigerators. All licensed nurses and Medication aides were inserviced by the Administrator, SDC Nurse and/or the QI Nurse, 10/15/2015 – 10/18/2015, regarding their responsibility to routinely check for and removed expired medications from the medication carts during their medication pass. This education will be provided to all licensed nursing and KMA new hires as well as agency staff as a part of orientation.

To monitor the effectiveness of this education and ensure continued compliance the Administrative Nurses including the ADON, SDC Nurse, QI Nurse, MDS Nurses and Treatment Nurse will check for expired medications in the medication carts during a weekly audit. The weekly med audit will become a routine procedure for the Administrative nurse to complete weekly. The Director of Nurses will check the refrigerators and

10/19/15

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

PRINTED: 10/08/2015
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 09/24/2015
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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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F 431 Continued From page 13

Review of the facility "Medication Expiration Dates", Policy, revised 01/01/14, revealed all house stock medications opened and unopened provided in the manufacturer's original package shall be considered expired when the manufacturer's expiration date has been reached.

Observation on 09/24/15 at 1:30 PM, revealed the refrigerator in the North Hall medication room had three (3) vials of Influenza Vaccine with an expiration date of 06/15; three (3) vials of Pure Protein Derivative (medication used for tuberculin testing) with an expiration date of 08/15; seven (7) Phenergan suppositories (medication used to treat allergic reactions and to treat nausea and vomiting) with an expiration date of 09/15; one (1) vial of Lantus Insulin with an expiration date of 04/15; ten (10) Phenergan suppositories (medication used to treat allergic reactions and to treat nausea and vomiting) with an expiration date of 04/15; and one (1) vial of Novalog N Insulin with an expiration date of 07/15.

Observation on 09/24/15 at 1:40 PM, revealed the medication cart on the North Hall had Arginaid (Nutritional Supplement) four (4) packets with an expiration date of 09/02/15; and Arginaid eight (8) packets with an expiration date of 06/15/15

Interview on 09/24/15 at 1:45 PM, with Registered Nurse (RN) #2, revealed expired medications should not be accessible in the medication room refrigerator, because if the medication was administered to a resident this could be harmful. Further interview with RN #2, revealed she was not sure what the facility's policy stated regarding

F 431 med rooms weekly for expired medications for one month, then monthly thereafter.

The results of these checks will be reported at the weekly QI meeting for four (4) weeks; then monthly x3. The results of these weekly/monthly QI meeting will be reported to the quarterly 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.

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

PRINTED: 10/08/2015
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 09/24/2015
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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F 431	Continued From page 14 who was responsible for checking the medication refrigerator for expired medications and how often the refrigerator needed to be checked.	F 431		
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Interview on 09/24/15 at 1:50 PM, with Licensed Practical Nurse (LPN) #1, revealed medication carts should be checked weekly on night shift and all expired medications/supplements should be discarded. LPN #1 stated she was unaware of the facility's policy regarding how often medication carts were checked and what the disposal protocol was for expired medications.

Observation on 09/24/15 at 2:00 PM, revealed the refrigerator in the medication room on the South Hall had three (3) bottles of Influenza vaccine with an expiration date of 06/15.

Observation on 09/24/15 at 2:10 PM, revealed the medication cart on the South Hall had Hydrocodone (medication used to treat pain) 5/325 milligrams (mg's) thirty nine (39) tablets with an expiration date of 08/26/15.

Interview on 09/24/15 at 2:20 PM, with LPN #2, revealed expired medications should not be in the medication room refrigerator or on the medication cart, because if given to a resident this could be harmful. Further interview with LPN #2, revealed the medication room refrigerator should be checked daily for expired medications, and the medication should be disposed of in the sharps containers if a glass container, but pills were disposed of differently.

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

PRINTED: 10/08/2015
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 09/24/2015
--	--	--	--

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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--------------------	--	---------------	---	----------------------

F 431 Continued From page 15

F 431

Interview on 09/24/15 at 2:30 PM, with the Director of Nursing (DON), revealed the refrigerators in the medication room should be inspected every Monday for expired medications/supplements by the Assistant Director of Nursing (ADON). She stated the medication cart should be checked routinely by nursing staff, and all expired medications should be sent back to the pharmacy.

Interview on 09/24/15 at 3:00 PM, with the facility Pharmacist, revealed the pharmacist checked for expired medications quarterly and it was nursing's responsibility to routinely check refrigerators and medication carts for expired medications in between. She stated the nursing staff were to pull expired medications from the carts and refrigerator, and place them on the South Hall until they were destroyed. She further stated she was unaware of the facility's policy regarding the disposal of expired medications.

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

F 441

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,

F441

Dietary staff thoroughly cleaned all nourishment refrigerators and discarded all outdated or undated food items on 9/23/2015.

The central line kit and lab tubes were discarded on 9/24/2015.

All residents have the potential to be affected.

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

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FORM APPROVED
OMB NO. 0938-0391

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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 441 Continued From page 16
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 direct contact will transmit the disease.

(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.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and review of the facility "Temperature Chart for Refrigerators and Freezers" log, dated 10/09/09, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe and sanitary environment.

Observation revealed two (2) of three (3) nourishment refrigerators on the South and

F 441 Dietary staff were in-serviced by the Dietary Manager regarding their responsibility to wipe up any spills, discard any outdated or undated food items each day when the nourishment station is stocked. Further each refrigerator will be thoroughly cleaned each Thursday by Dietary staff and all items checked for proper labeling, dating, and expiration dates. Any inappropriate or expired items will be discarded. This education was completed 10/13/2015 - 10/18/2015. This education will be provided all new dietary hires or agency staff as a part of orientation.

All staff, including all Department Managers, RNs, LPNs, SRNAs, Dietary Staff, and Housekeeping Staff were in-serviced by the Administrator, SDC Nurse and/or QI Nurse, 10/15/2015 - 10/18/2015, regarding appropriately documenting refrigerator and freezer temperatures twice daily on the temperature logs for each refrigerator. The refrigerator temperatures are recorded by the Nurse/KMA assigned to the hallway in which the refrigerator is located. This education will be provided to all licensed nursing and KMA new hires as well as agency staff as a part of orientation.

10/19/15

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

PRINTED: 10/08/2015
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 09/24/2015
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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--------------------	--	---------------	---	----------------------

F 441 : Continued From page 17
Memory Care units contained outdated food products, sticky lower shelves, soiled door shelves, and unidentified and undated food items. Further observation revealed the temperature logs for the South and Memory Units nourishment refrigerators were recorded prior to the Post Meridian (PM) time and the North Unit nourishment refrigerator temperature log was incomplete.

In addition, observation of the South Hall medication room revealed a Central Line Kit with an expiration date of 06/15 and fifty five (55) lab tubes with an expiration date of 02/15.

The findings include:

1. Interview on 09/24/15 at 5:00 PM, with the Dietary Manager (DM) revealed there was no facility policy related to the nourishment refrigerators on the units.

Review of the facilities "Temperature Chart for Refrigerators and Freezers" log, dated 10/09/09 revealed the corrective action to be taken if the temperature was not within the correct range for refrigerator and freezers was to contact immediately the maintenance department and manager.

Observation on 09/22/15 at 11:40 AM, of the South Unit nourishment refrigerator revealed no light inside the refrigerator, dried dark colored substance on the refrigerator door shelves, a light

F 441 The Assistant Director of Nurses was in-serviced by the Director of Nurses on 9/28/2015 regarding her responsibility to properly check for and pull any expired supplies located in the medication storage rooms during her weekly inspection of the medication rooms.

To monitor the effectiveness of this education and ensure continued compliance with the Infection Control Program, the QI Nurse or her designee will inspect the nourishment refrigerators weekly for cleanliness, expired items and appropriate documentation of temperatures weekly for one month, then monthly thereafter. The Director of Nurses or her designee will check the medication storage rooms weekly for expired supplies for one month, then monthly thereafter.

The results of these checks will be reported at the weekly QI meeting for four (4) weeks; then monthly x 2. The results of these weekly/monthly QI meeting will be reported to the quarterly 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

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

PRINTED: 10/08/2015
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 09/24/2015
--	--	--	--

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 441 | Continued From page 18
pink sticky substance on the lower refrigerator shelf and three (3) wrapped sandwiches which adhered to the sticky substance, an undated identified residents' potato salad and a frozen entree' Michaela's Sweet and Sour Chicken with no resident identification. Continued observation revealed the refrigerator drawer had a tomato in an undated container with no resident identification. The tomato had a white mold like substance that had grown within the container. The refrigerator drawer also contained a slice of an unknown yellow vegetable which was undated with no resident identification and a mold like substance had grown in the container.

Further review of the Facilities "Temperature Chart for Refrigerators and Freezers" log for the South Unit nourishment room refrigerator revealed no column for the freezer temperatures to be recorded and the temperature log had been recorded prior to the (PM) time.

Observation on 09/22/15 at 11:53 AM, of the Memory Care nourishment refrigerator revealed a package of one (1) pound Smoked Honey Turkey Breast meat and a jar of Kraft Mayonnaise five (5) ounces with no resident identification. The nourishment refrigerator contained a dried dark colored substance on the refrigerator door shelves, a light pink sticky substance on the lower refrigerator shelf and two (2) wrapped sandwiches which adhered to the sticky substance. Continued observation of the refrigerator drawer revealed a clear wrapped sausage egg biscuit with no resident identification which was undated, and an eight (8) ounce container of Yoplait Greek Whips Yogurt dated

F 441 | QI Committee will make recommendations for further action based upon the data presented.

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

PRINTED: 10/08/2015
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 09/24/2015
--	--	--	--

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 441 Continued From page 19
09/15/15 which was outdated. F 441

Further review of the Facilities "Temperature Chart for Refrigerators and Freezers" log, for the Memory Care nourishment refrigerator revealed no column for the freezer temperatures to be recorded and the temperature log had been recorded prior to the (PM) time.

Observation on 09/22/15 at 12:00 PM of the North Unit nourishment refrigerator "Temperature Chart for Refrigerators and Freezers" log, revealed no column for the freezer temperatures to be recorded and the temperatures were not recorded for six (6) days on 09/11/15, 09/16/15, 09/17/15, 09/18/15, 09/19/15 and 09/21/15.

Interview on 09/23/15 at 2:35 PM, with Dietary Aide #1, revealed the Dietary Department was responsible for taking snacks to the units, cleaning the refrigerators and rotating the snacks. Further interview, revealed all snacks should be dated.

Interview on 09/23/15 at 2:40 PM with Cook #1, revealed the Dietary Aide assigned was to take the snacks to the units, check temperatures of the nourishment refrigerators at night, rotate the snacks and check for perishable food items. Cook #1 stated the snacks were to be dated so the snacks could be rotated. Cook #1 further stated, the Dietary Aide who took the snacks was responsible for cleaning the nourishment refrigerator.

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

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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 09/24/2015
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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 441 Continued From page 20

F 441

Interview on 09/23/15 at 3:05 PM, with the DM, revealed it was dietary's responsibility to keep the nourishment refrigerators clean, snacks dated and rotated. The DM stated there could be a potential for cross contamination if the food items were not rotated and the nourishment refrigerators were not cleaned daily. She further revealed the temperatures of the refrigerators and freezers should be obtained and documented in the morning and evening.

Interview on 09/23/15 at 4:00 PM, with the Administrator, revealed the Dietary department was responsible for cleaning the nourishment refrigerators. She stated her expectation was for the Dietary Department to handle snacks in a proper manner.

2. Observation on 09/24/15 at 2:00 PM of the South Hall medication room revealed a Central Line Kit with an expiration date of 08/15 and fifty five (55) lab tubes with an expiration date of 02/15.

Interview on 09/24/15 at 2:30 PM, with the Director of Nursing (DON), revealed all medical supplies should be checked routinely by nursing staff, and expired medical supplies discarded as per facility protocol.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 10/26/2015
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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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{K 000} INITIAL COMMENTS

{K 000}

Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/17/15 as alleged.

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.

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

Acceptable for 10/26/15

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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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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 09/24/15 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-two (95) the day of the survey.

The highest Scope and Severity was at the "D" 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Admin.	(X6) DATE 10/16/17
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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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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
K 029 SS=D	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twelve (12) residents, staff and visitors.</p> <p>The findings included:</p> <p>Observation on 09/24/15 at 1:39 PM, with the Maintenance Director, revealed rooms 168 and 169 was being used for storage of various items and the doors were not equipped with self-closers. Interview, with the Maintenance Director, at the time of observation, revealed the Maintenance Director was aware the doors would need to be equipped with self-closers.</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2.1 Hazardous Areas. Any hazardous areas</p>	K 029 K029	<p>Self-closers were installed on the doors of rooms 168 and 169 by the Maintenance Director on 9/30/2015. 10/17/15</p> <p>The Maintenance Director surveyed the remaining doors within the facility on 09/25/2015 to determine that all other storages areas had self-closers on the doors.</p> <p>All staff were educated 10/15/2015 – 10/16/2015 regarding new door closers and the need to keep the doors to the storage rooms closed at all times.</p> <p>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 storage rooms doors being securely closed. Any concerns identified during these rounds will be addressed & corrected as indicated. The QI Rounds tools and the results</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 029 Continued From page 2

shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:

- (1) Boiler and fuel-fired heater rooms
- (2) Central/bulk laundries larger than 100 ft² (9.3 m²)
- (3) Paint shops
- (4) Repair shops
- (5) Soiled linen rooms
- (6) Trash collection rooms
- (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction
- (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K 130 NFPA 101 MISCELLANEOUS

SS=D

OTHER LSC DEFICIENCY NOT ON 2786

K 029

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.

K 130

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

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K 130¹ Continued From page 3

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure electrical panels were labeled properly, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty-nine (29) residents, staff and visitors.

The findings include:

Observation, on 09/24/15 at 1:42 PM, with the Maintenance Director, revealed electrical panel LPA did not have the circuit breakers labeled properly, to indicate the circuit breakers were spares. Further observation revealed electrical panels LPB and LP1 did not have breakers labeled properly, to indicate the circuit breakers were spares. Interview, with Maintenance Director at the time of observation, revealed he was not aware the circuit breakers needed to be labeled as spares if the circuit breakers functioned as spares.

The findings were acknowledged by the Administrator at the exit conference.

Reference: NFPA 70 (1999 Edition)

110-22. Identification of Disconnecting Means. Each disconnecting means required by this Code for motors and appliances, and each service, feeder, or branch circuit at the point where it originates, shall be legibly marked to indicate its purpose unless located and arranged so the

K 130
K130:

The Maintenance Director labeled all the spare circuit breakers in electrical panels LPA, LPB and LP1 to indicate they were spare breakers. This was completed 10/25/2015. *10/17/15*

A policy was developed by the Administrator and Maintenance Director that all spare circuit breakers shall be labeled as spare.

All staff will be in-serviced with regard to the new policy by the Staff Facilitator and/or Administrator at in-services to be completed 10/16/2015.

Maintenance will monitor the labeling of the electrical panels as a part of their monthly/ annual electrical inspection rounds. This will be reported through the Safety Committee's monthly report 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.

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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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K 130 Continued From page 4 K 130

purpose is evident. The marking shall be of sufficient durability to withstand the environment involved. Where circuit breakers or fuses are applied in compliance with the series combination ratings marked on the equipment by the manufacturer, the equipment enclosure(s) shall be legibly marked in the field to indicate the equipment has been applied with a series combination rating. The marking shall be readily visible and state the following:
CAUTION - SERIES COMBINATION SYSTEM
RATED _____ AMPERES. IDENTIFIED.
REPLACEMENT COMPONENTS REQUIRED.
FPN: See Section 240-83(c) for interrupting rating marking for end-use equipment.