

Jan. 22. 2016 2:08PM

No. 1490 P. 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/29/2015
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 C 12/11/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 86 STATE ROAD 3444 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 A standard health survey was conducted on 12/09-11/15. Deficient practice was identified with the highest scope and severity at "F" level. An abbreviated survey (KY24122) was also conducted at this time. The complaint was substantiated with deficient practice identified.	F 000	The preparation and execution of this Plan does not constitute an admission or agreement by the facility of the truth of the alleged facts or conclusions set forth in the SOD. This POC is prepared and execute solely because it is required by Federal and State law.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledgo it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	The employee who made the accusation was interviewed by the administrator and when asked what happened she said that she heard a loud slapping sound, at that time she made no claim of seeing anything related to a slap. She also said that her coworker said S.O.B. but she said that the person was not saying it to the resident but said it loudly where the resident could hear. She further stated that there was a visitor outside the open door who was a witness to the activity. This reliable visitor was interviewed and did verify that they were right outside the door the entire time and that they could hear what was going on inside the room. They heard no loud slapping sound and they heard no one use any foul language. The employee in question was suspended, the resident was assessed and there was no evidence of any injury. Confused residents were given a skin assessment to	

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

P.A. Walker

TITLE

Adm

(X6) DATE:

1-22-16

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 citations are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 98 STATE ROAD 3444 ANNVILLE, KY 40402	
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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure an incident of alleged abuse was reported to the State Survey Agency for one (1) of thirteen (13) sampled residents (Resident #5). Facility staff was alleged to "slap" Resident #5's thigh leaving a red mark and called the resident a "Son of a Bitch" when the State Registered Nursing Assistant (SRNA) found the resident wet and had to change the bed linen on 11/27/15. The incident was reported to Administration and the alleged perpetrator was suspended pending the outcome of an investigation. However, the allegation of abuse was not reported to the State Survey Agency.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect, and Misappropriation," effective date April 2013, revealed all allegations of abuse would be investigated and reported to the appropriate agencies. The policy further noted the Administrator and/or Director of Nursing (DON) would be responsible to notify the state agencies in accordance with facility guidelines.</p>	F 225	<p>assure that there were no unexplained injuries. Other residents were interviewed and no one had been mistreated nor had they heard or seen any other resident mistreated. The physician, family and APS were notified. Since no credible allegation had been made the decision to not report to OIG was made at that time. We did report the allegation to OIG on 11/29/15.</p> <p>1) In this instance no resident was affected since an investigation took place and there was no evidence that any type of abuse had occurred however policy/procedure has changed so that incidences like this would be reported to both OIG and APS as well as law enforcement if warranted. All staff have been in-service on the facilities abuse policy, including proper reporting by facility or corporate staff with this training being completed on or before 12/4/15 for most staff and upon return to work for others. Another in-service was held on 12/18/15 for all nursing staff to reinforce proper use of the abuse policy including reporting.</p> <p>2) Residents with BIMS score of 8 or > were interviewed for any allegations of abuse by the SSD on 12/1/15 and residents with BIMS score of 7 or < had a skin assessment completed by</p>	

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F 225	<p>Continued From page 2</p> <p>Record review revealed the facility admitted the resident on 09/13/05, with diagnoses that included Convulsions, Chronic Embolism and Thrombosis, Intracranial Injury, Aphasia, and Dysphagia. Review of the Annual Minimum Data Set (MDS) assessment completed on 09/04/15 revealed the facility assessed the resident to require extensive physical assistance of two persons with transfers and toileting, and to be incontinent of bowel and bladder function. Further review of the MDS assessment revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be (blank), determining the resident to be unable to complete the interview. Review of the Care Plan revealed the facility determined an approach for staff to provide incontinence care every two hours for Resident #5 and to utilize briefs for incontinence control.</p> <p>Observations of Resident #5 on 12/09/15 at 3:00 PM revealed the resident was lying in bed on his/her right side with a fall mat on the floor on the left side of the bed and the right side of the bed was against the wall. A skin assessment was conducted with facility staff for Resident #5 on 12/09/15 at 4:00 PM. No bruises or redness was identified on the resident's thighs.</p> <p>Review of the facility's investigation initiated on 11/28/15 revealed SRNA #9 reported she observed SRNA #10 slap Resident #5 on the thigh and call the resident a "Son of a Bitch" after finding the resident's bed wet with urine on 11/27/15. The investigation revealed SRNA #10 was immediately suspended pending the outcome of the investigation and SRNA #9 was re-educated regarding reporting the incidence of abuse/neglect. The allegation was reported to</p>	F 225	<p>the nursing staff on 12/2/15 for signs & symptoms of abuse. No issues were found.</p> <p>3) Administrator, DON and/or Abuse Coordinator will ensure all allegations are logged on the abuse log daily and review the abuse log sheet daily during stand up meeting to ensure all newly reported allegations have been reported to the appropriate regulatory agencies in a timely manner.</p> <p>4) The facility now uses a QA program, Abaqis, to monitor resident care including allegations of abuse. Forty randomly selected residents are chosen and they, their family or staff are interviewed to determine quality of care including any perceived abusive behavior. If any abuse is mentioned during interviews it is determined whether this is a first report and if so an investigation is instigated and the matter reported to state agencies per our policy. If previously disclosed records are checked to make sure that a full investigation had taken place and that procedures had been followed including proper reporting to state agencies. Any allegation of abuse is automatically reported to facility administration as well as to pertinent corporate staff. This process occurs 3</p>	

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F 225	Continued From page 3 the Administrator and DON on 11/28/15. The investigation further revealed the Department for Community Based Services was notified on 11/28/15; however, there was no evidence the state survey agency was notified of the allegation of abuse. Interview with the Director of Nursing on 12/10/15 at 3:13 PM revealed she conducted the investigation and suspended the alleged perpetrator according to facility policy. The DON stated she reported the allegation and the information she collected during the investigation to the corporate office. The DON stated she was told by corporate staff not to report to the state survey agency because there was "nothing to report." The DON stated, "We should have reported" the incident. Interview with the Administrator on 12/10/15 at 3:52 PM revealed he had been made aware of the allegation on 11/28/15 and had conducted some interviews with the residents to determine if any other residents had possibly been affected. The Administrator stated the corporate staff had directed that the allegation not be reported to the state agencies. The Administrator stated corporate staff said the allegation was "not reportable." The Administrator stated he did not believe abuse occurred but he would probably have reported it to the state survey agency.	F 225	times per year. Any new allegations of abuse would be reported to the appropriate state agencies immediately by the administrator, DON or Abuse coordinator.	1/8/16
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	1) Residents #2, #4, #6 had their catheters secured with Velcro leg straps on 12/11/15 by the resident's	

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F 279	<p>Continued From page 4</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview, record review, and facility policy review, it was determined the facility failed to develop a plan of care for three (3) of thirteen (13) sampled residents (Resident #2, Resident #4, and Resident #6) to address risk factors related to the use of an indwelling catheter. Residents #2, #4, and #6 were observed to have unsecured indwelling catheter tubing and review of the medical records revealed the comprehensive care plan did not include interventions to address securing of the indwelling catheter tubing to prevent trauma to the urinary tract.</p> <p>The findings include: Review of facility policy "Care Planning- Interdisciplinary Team," dated 06/01/15, revealed, "Facility's Care Planning/Interdisciplinary Team is</p>	F 279	<p>nurse. Care plans were updated on 1/5/16 by the MDS Coordinator.</p> <p>2) All residents were assessed for utilization of Foley catheter on 12/11/15 by the nursing staff. Care plans were updated as needed to ensure current resident care needs are met. Three residents were noted to utilize Foley catheters, all catheters were properly secured with Velcro leg straps, verified by the residents nurse on 12/11/15.</p> <p>3) Nursing staff were educated on the catheter care policy and procedure to include appropriately securing Foley catheter and the care plan policy and procedure to include updating residents care plan to reflect residents current care need by the DON on 12/11/15 and 12/18/15 with any who missed the training trained on their next day at work by the DON or her designee.</p> <p>4) The DON will review care plans for all residents with catheters monthly and report care plan reviews to the QA committee quarterly to assure compliance.</p> <p>5)</p>	1/31/16	

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F 279	<p>Continued From page 5</p> <p>responsible for the development of an individualized comprehensive care plan for each resident, incorporating goals and objectives that lead to the residents' highest obtainable level of independence."</p> <p>Review of facility policy, "Foley Catheter Care," dated 05/08/06, revealed the policy did not address the process of securing the indwelling catheter tubing.</p> <p>Review of "Catheterization Guideline Steps," undated, revealed indwelling catheter tubing should be taped or staff should apply a Velcro leg strap. The guidelines further stated that staff should never leave the room until the catheter was secured. The guidelines stated that the mechanical irritation caused by catheter movement could cause urethral and meatal tearing, accidental removal, and serious complications.</p> <p>Review of "Lippincott Manual of Nursing Practice, Ninth Edition," revealed "Management of the Patient with an Indwelling Catheter and Closed Drainage System" included securing the indwelling catheter to the patient's thigh using tape, strap, adhesive anchor, or other securement device. The manual further revealed, "Properly securing the catheter prevents catheter movement and traction on the urethra."</p> <p>1. Review of the medical record revealed the facility admitted Resident #2 on 05/03/10 with diagnoses of Urinary Retention, Type I Diabetes Mellitus, Domontia, Cerebral Infarction, Homiplegia, and Gastrostomy. Review of the Annual Minimum Data Set (MDS) assessment</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>dated 11/19/15 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9 and required total assistance of two or more staff persons for toileting, personal hygiene, and bathing. Review of the 08/27/15 Quarterly MDS as well as the 11/19/15 Annual MDS revealed an indwelling catheter.</p> <p>Further review of Resident #2's medical record revealed a comprehensive care plan dated 11/23/15. The care plan identified a problem of an indwelling catheter with a goal to "maintain as clean, dry and odor free as possible, maintain urinary output." The approach or interventions related to the indwelling catheter included care of the catheter every shift and as needed, as well as instructions to keep the catheter bag covered and below the level of the bladder. Review of Resident #2's care plan revealed no interventions that addressed risk factors related to the use of the indwelling catheter.</p> <p>Observation of Resident #2's perineal care/catheter care on 12/09/15 at 4:10 PM by State Registered Nurse Aide (SRNA) #1 revealed indwelling catheter tubing was not secured before or after perineal/catheter care.</p> <p>Observation of Resident #2's skin assessment on 12/09/15 at 4:25 PM by Registered Nurse (RN) #1 revealed the indwelling catheter tubing was not secured before or after skin assessment.</p> <p>2. Review of Resident #4's medical record revealed the facility admitted Resident #4 on 12/14/12 with diagnoses of Urinary Retention, Mild Intellectual Disabilities, Heart Failure, and Convulsions. Review of the Significant Change MDS assessment dated 10/01/15 revealed</p>	F 279			

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F 279	<p>Continued From page 7</p> <p>Resident #4 had a BIMS score of 15 and required extensive to total assistance of two staff persons for toileting, personal hygiene, and bathing. Resident #4 returned to the facility on 08/06/15 from the hospital with an indwelling catheter and diagnosis of urinary retention.</p> <p>Review of Resident #4's medical record revealed a care plan dated 10/05/15 identifying an indwelling catheter related to urinary retention as a problem. Interventions related to the indwelling catheter included measuring and recording output, observing for changes in output, catheter care every shift, and keeping the catheter bag covered and below the level of the bladder. Review of Resident #4's care plan regarding the indwelling catheter revealed no interventions that addressed risk factors related to the use of the indwelling catheter.</p> <p>Observation of Resident #4 on 12/11/15 at 9:35 AM revealed the indwelling catheter tubing was not secured to the resident's leg.</p> <p>3. Review of Resident #6's medical record revealed the facility admitted Resident #6 on 07/22/15 with diagnoses of Urinary Retention, Stage IV Pressure Ulcer to Sacral Region, Convulsions, and Large Pelvic Mass. Review of the Quarterly MDS dated 11/07/15 revealed Resident #6 had a BIMS score of 3 and required total assistance of two staff persons for personal hygiene and bathing. Review of the 11/07/15 Quarterly MDS also revealed the resident had an indwelling catheter.</p> <p>Review of Resident #6's medical record revealed a care plan identifying an indwelling catheter related to skin breakdown on 07/29/15 with an</p>	F 279			

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F 279	<p>Continued From page 8</p> <p>updated problem data on 10/27/15. Interventions related to the indwelling catheter included catheter care every shift and as needed, empty and measure urine every shift and report odor, color, and output to Nursing. Review of Resident #6's care plan regarding the indwelling catheter revealed no interventions that addressed risk factors related to the use of the indwelling catheter.</p> <p>Observation of perineal care on 12/10/15 at 10:05 AM provided by SRNA #4 for Resident #6 revealed the catheter tubing was not secured before perineal care began, nor was it secured by SRNA #4 after perineal care was completed.</p> <p>Observation of wound care and the skin assessment for Resident #6 on 12/10/15 at 10:15 AM by RN #3 and RN #1 revealed the indwelling catheter tubing was not secured to Resident #6's leg before the wound care and skin assessment were initiated nor was it secured by RN #1 or RN #3 after wound care and the skin assessment were completed.</p> <p>Interview with SRNA #5 on 12/11/15 at 1:10 PM revealed she was trained to use the clip on the tubing to secure the tubing to the sheet. SRNA #5 stated she reviewed her care plans every day for instructions related to resident care.</p> <p>Interview with SRNA #2 on 12/11/15 at 1:17 PM revealed she stated that the facility had leg straps to secure the catheter tubing but did not know why they were not being used. She stated she was trained to hang the bag on the bed frame below the bladder and use the clip on the tubing to secure the tubing to the sheet.</p>	F 279			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN

88 STATE ROAD 3444
ANNVILLE, KY 40402

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F 279	<p>Continued From page 9</p> <p>Interview with RN #1 on 12/11/15 at 1:25 PM revealed she communicated verbally with SRNAs regarding communication of interventions of care and also stated the SRNAs should be referring to care plans for instruction. RN #1 stated facility policy regarding care of the catheter tubing and bag was to make sure the catheter bag remained below the bladder, the bag was covered, and the clip on the tubing should be clipped to the sheet or leg strap used to secure catheter tubing.</p> <p>Interview with the MDS Coordinator revealed the Care Plan Team met weekly. The MDS Coordinator stated the Care Plan team consisted of the Director of Nursing (DON), a RN, the Activity Coordinator, Social Services Coordinator, and the MDS Coordinator among others. The MDS Coordinator explained that while the Care Plans were updated when the MDS's were completed, acute problems should be updated by the Nurso when a new problem is identified.</p> <p>Interview with the Director of Nursing (DON) on 12/11/15 at 1:57 PM revealed the Care Plan Committee met weekly to develop and revise care plans. She revealed a Temporary Care Plan would be developed upon admission followed by the primary Comprehensive Care Plan once the Team met and the MDS was completed. The DON stated the care plans were then updated quarterly or with significant changes.</p>	F 279		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>	F 312	<p>Please note that both of the residents mentioned often refuse care including nail care.</p> <p>1) On 12/11/15 the nails for resident # 4 were cleaned and trimmed by the residents nurse.. For resident #7 nails</p>	

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No. 1490 P. 11

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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 12/11/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE: 98 STATE ROAD 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIREMENT 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 312	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based upon observation, interview, record review, and facility policy review, it was determined the facility failed to ensure two (2) of thirteen (13) sampled residents (Resident #4 and Resident #7) received necessary services to maintain grooming related to nail care. Observations of Residents #4 and #7 revealed long, and/or dirty fingernails/toenails. The findings include: Review of the facility policy titled "Nail Care for Clipping," undated, revealed the facility was to provide adequate clipping of nails for all residents as needed. 1. Review of Resident #4's medical record revealed the facility admitted Resident #4 on 12/14/12 with diagnoses of Urinary Retention, Mild Intellectual Disabilities, Heart Failure, Convulsions, Atherosclerotic Heart Disease, and Hypertension. Review of the Significant Change Minimum Data Set (MDS) assessment dated 10/01/15 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 and required extensive to total assistance of two staff persons for toileting, personal hygiene, and bathing. Review of the Comprehensive Care Plan, dated 10/05/15, revealed Resident #4 required extensive to total care with regard to activities of daily living (ADLs). The care plan included interventions of assistance of two staff persons	F 312	were trimmed on 12/11/15 by a family member who is a nurse. 2) All residents fingernails and toenails were assessed on 12/11/15 by the residents nurse and nails were trimmed as appropriate and if needed podiatry visits were scheduled to assure that resident nail care needs are met.. 3) Nursing staff were educated on the nail care policy and procedure on 12/18/15 by the DON. Residents will be scheduled for podiatry appointments as needed to meet their nail care needs. 4) The DON, SDC or another nurse will check nails of six resident's for proper care weekly for 4 weeks and monthly for two months and quarterly thereafter for a total of one year. Results will be reported to the QA committee for review. 5)	1/31/16	

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F 312	<p>Continued From page 11</p> <p>for bed mobility, transfers, dressing every day and as needed, toileting, and staff assistance with bathing daily and as needed. The care plan also included assistance of one to two staff persons for hygiene every shift and as needed and assistance to turn and reposition Resident #4 every two hours and as needed. Further review of the Care Plan revealed the care plan did not include assistance to be provided for nail care. Review of the care plan utilized by State Registered Nursing Assistants (SRNAs) revealed the care plan addressed the need for assistance with showering or bathing, dressing, and oral care. The SRNA care plan did not include nail care to be provided by the SRNAs.</p> <p>Review of the Medication Administration Record (MAR), dated 11/01/15 - 11/30/15, revealed instructions for nail care weekly on Mondays.</p> <p>Review of the Weekly Skin Integrity Review, dated 12/08/15, revealed the condition of fingernails or toenails was not addressed.</p> <p>Observation of Resident #4 on 12/11/15 at 9:35 AM revealed Resident #4 had long fingernails and toenails to all digits.</p> <p>2. Review of the medical record revealed the facility admitted resident #7 on 11/06/14 with diagnoses of Hypertension, Dementia Without Behavior, Arthropathy, Major Depressive Disorder, and Chronic Pain. Review of the Annual MDS assessment dated 11/12/15, revealed a BIMS score of 15. In addition, the assessment revealed the resident required extensive assistance of two staff persons for eating, toileting, personal hygiene, and bathing.</p>	F 312		

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F 312	<p>Continued From page 12</p> <p>Further review of the medical record of Resident #7, specifically the Comprehensive Care Plan dated 11/17/15, revealed the resident had "ADL impairment" and required extensive assistance with ADLs. The care plan further stated the resident preferred the "family to batho." Further review of the care plan revealed the goal was to "provide daily ADL care needs" and interventions that included staff assistance of two for repositioning in recliner, transfers, walking with walker, dressing every day and as needed, toileting, and personal hygiene every day and as needed.</p> <p>Review of the Care Plan used by the SRNAs revealed Resident #7 required the assistance of two staff persons for shower, shampoo, and dressing, and assistance of one for oral care. The SRNA care plan did not include interventions related to assistance with grooming or nail care.</p> <p>Review of the MAR for Resident #7, dated 11/01/15 - 11/30/15, revealed instructions for "nail care weekly on Tuesday."</p> <p>Observation of skin assessment with RN #5 on 12/10/15 at 1:25 PM revealed Resident #7 had very long and discolored nails on both hands with a dark substance underneath the fingernails.</p> <p>Interview with SRNA #2 revealed she checked the Aide Care Plan every morning because "it tells you over everything need to know."</p> <p>Interview with SRNA #5 revealed she reviewed her Aide Care Plans every day for instructions related to resident care.</p> <p>Interview with RN #5 on 12/10/15 at 1:25 PM</p>	F 312		

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F 312	Continued From page 13 revealed the "family prefers to take care of nails and personal care" for Resident #7. Interview with RN #1 on 12/11/15 at 1:25 PM revealed she communicated verbally with SRNAs regarding communication of interventions of care and also stated the SRNAs should be referring to their care plans for instruction. Interview with the Director of Nursing (DON) on 12/11/15 at 1:57 PM revealed nurses should be making rounds every two hours and she made rounds two to thoo times a day to monitor care. She revealed a Temporary Care Plan would be developed upon admission followed by the primary Comprehensive Care Plan once the Team met and the MDS was completed. They were then updated quarterly or with significant changes. Tho DON continued to explain 24-hour checks followed, where the MDS nursos checked Doctor orders and ensured care plans were updated. No reasons were provided why nail care was not provided to these residents.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on tho resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	1) Residents #2, #4, #6 had their catheters secured with Velcro leg straps on 12/11/15 by the resident's nurse. Care plans were updated on 1/5/16 by the MDS Coordinator. 2) All residents were assessed for utilization of Foley catheter on 12/11/15 by the nursing staff. Three residents were noted to utilize Foley catheters, all cathoters were properly secured with Velcro leg straps,	

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F 315	Continued From page 14 This REQUIREMENT is not met as evidenced by: Review of the 08/27/15 Quarterly MDS as well as the 11/19/15 Annual MDS revealed an indwelling catheter. Based upon observation, interview, record review, and facility policy review, it was determined the facility failed to provide appropriate treatment and services to prevent excessive tension on the catheter, for three (3) of thirteen (13) sampled residents (Resident #2, Resident #4, and Resident #6). Observations revealed Residents #2, #4, and #6 had indwelling catheters that were unsecured placing residents at risk for trauma to the urinary tract. The findings include: Review of facility policy, "Foley Catheter Care," dated 05/08/08, revealed the policy did not address the process of securing the indwelling catheter tubing. Review of "Catheterization Guidelines Steps," undated, revealed indwelling catheter tubing should be taped or staff should apply a Velcro leg strap. The guidelines further stated that staff should never leave the room until the catheter was secured. The guidelines stated that the mechanical irritation caused by catheter movement could cause urethral and meatal tearing, accidental removal, and serious complications. Review of "Lippincott Manual of Nursing Practice, Ninth Edition," revealed, "Management of the Patient with an Indwelling Catheter and Closed Drainage System" included securing the indwelling catheter to the patient's thigh using	F 315	verified by the residents nurse on 12/11/15. 3) Nursing staff were educated on the catheter care policy and procedure to include appropriately securing Foley catheter and the care plan policy and procedure to include updating residents care plan to reflect residents current care need on 12/11/15 and 12/18/15 by the DON, anyone who missed the training were trained upon their return to work by the DON or her designee. 4) The DON will review care plans for all residents with catheters monthly and report care plan reviews to the QA committee quarterly to assure compliance. 5)	1/31/16	

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F 315	<p>Continued From page 15</p> <p>tape, strap, adhesive anchor, or other securement device. The manual further revealed, "Properly securing the catheter prevents catheter movement and traction on the urethra."</p> <p>1. Review of the medical record revealed the facility admitted Resident #2 on 05/03/10 with diagnoses of Urinary Retention, Type I Diabetes Mellitus, Dementia, Cerebral Infarction, Hemiplegia, and Gastrostomy. Review of the Annual Minimum Data Set (MDS) assessment dated 11/19/15 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9 and required total assistance of two or more staff persons for toileting, personal hygiene, and bathing. Review of the 08/27/15 Quarterly MDS as well as the 11/19/15 Annual MDS revealed an indwelling catheter.</p> <p>Further review of Resident #2's medical record revealed a comprehensive care plan dated 11/23/15. The care plan identified a problem of an indwelling catheter with a goal to "maintain as clean, dry and odor free as possible, maintain urinary output." The approach or interventions related to the indwelling catheter included care of the catheter every shift and as needed, as well as instructions to keep the catheter bag covered and below the level of the bladder. Review of Resident #2's care plan revealed no interventions that addressed risk factors related to the use of the indwelling catheter.</p> <p>Observation of Resident #2's perineal care/catheter care on 12/09/15 at 4:10 PM by State Registered Nurse Aide (SRNA) #1 revealed indwelling catheter tubing was not secured before or after perineal/catheter care.</p>	F 315			

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F 315	Continued From page 16 Observation of Resident #2's skin assessment on 12/09/15 at 4:25 PM by RN #1 revealed the indwelling catheter tubing was not secured before or after skin assessment. 2. Review of Resident #4's medical record revealed the facility admitted Resident #4 on 12/14/12 with diagnoses of Urinary Retention, Mild Intellectual Disabilities, Heart Failure, and Convulsions. Review of the Significant Change MDS assessment dated 10/01/15 revealed Resident #4 had a BIMS score of 15 and required extensive to total assistance of two staff persons for toileting, personal hygiene, and bathing. Review of the medical record also revealed an indwelling catheter following a return from the hospital on 08/06/15. Review of Resident #4's medical record revealed a care plan dated 10/05/15 identifying an indwelling catheter related to urinary retention as a problem. Interventions related to the indwelling catheter included measuring and recording output, observing for changes in output, catheter care every shift, and keeping the catheter bag covered and below the level of the bladder. Review of Resident #4's care plan regarding the indwelling catheter revealed no interventions that addressed risk factors related to the use of the indwelling catheter. Observation of Resident #4 on 12/11/15 at 9:35 AM revealed the indwelling catheter tubing was not secured to the resident's leg. 3. Review of Resident #6's medical record revealed the facility admitted Resident #6 on 07/22/15 with diagnoses of Urinary Retention,	F 315			

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F 315	<p>Continued From page 17</p> <p>Stage IV Pressure Ulcer to Sacral Region, Convulsions, and Large Pelvic Mass. Review of the Quarterly MDS dated 11/07/15 revealed Resident #8 had a BIMS score of 3 and required total assistance of two staff persons for personal hygiene and bathing and that Resident #8 also had an indwelling catheter.</p> <p>Review of Resident #8's medical record revealed a care plan identifying an indwelling catheter related to skin breakdown on 07/29/15 with an updated problem date on 10/27/15. Interventions related to the indwelling catheter included catheter care every shift and as needed, empty and measure urine every shift, and report odor, color, and output to Nursing. Review of Resident #8's care plan regarding the indwelling catheter revealed no interventions that addressed risk factors related to the use of the indwelling catheter.</p> <p>Observation of perineal care on 12/10/15 at 10:06 AM provided by SRNA #4 for Resident #8 revealed the catheter tubing was not secured before perineal care began, nor was it secured by SRNA #4 after perineal care was completed.</p> <p>Observation of wound care and the skin assessment for Resident #8 on 12/10/15 at 10:15 AM by RN #3 and RN #1 revealed the indwelling catheter tubing was not secured to Resident #8's leg before the wound care and skin assessment were initiated nor was it secured by RN #1 or RN #3 after wound care and the skin assessment were completed.</p> <p>Interview with SRNA #5 on 12/11/15 at 1:10 PM revealed she believed the facility policy regarding the care of the tubing and bag of indwelling</p>	F 315			

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F 315	Continued From page 18 catheters was to be sure the catheter bag was kept off the floor and that it should be attached to the bed with a clamp. She stated she was trained to use the clip on the tubing to secure the tubing to the sheet. Interview with SRNA #2 on 12/11/15 at 1:17 PM revealed she stated that the facility had leg straps to secure the tubing but did not know why they were not being used. SRNA #2 stated she was trained to hang the bag on the bed frame below the bladder and use the clip on the tubing to secure the tubing to the sheet. Interview with RN #1 on 12/11/15 at 1:25 PM revealed she verbally communicated with SRNAs regarding communication of interventions of care. RN #1 stated she was responsible for SRNA training. RN #1 stated facility policy regarding care of the catheter tubing and bag was to make sure the catheter bag remained below the bladder, the bag was covered, and the clip on the tubing should be clipped to the sheet or a leg strap used to secure the catheter tubing. Interview with the Director of Nursing (DON) on 12/11/15 at 1:57 PM revealed catheter tubing should be secured to the resident's leg. The DON explained that nurses made rounds every two hours and she also made rounds throughout the day and week looking at safety issues and infection control as well as care issues.	F 315			
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is	F 364	Staff were disorganized and much slower than normal. Many were relatively new and had never been through the survey process before and appeared nervous		

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F 364	<p>Continued From page 19</p> <p>palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined the facility failed to serve food at a palatable temperature. Observation on 12/09/15 revealed lunch trays were not served in a timely manner and food was not at a palatable temperature.</p> <p>The findings include:</p> <p>Review of the facility policy related to food preparation, dated August 2014, revealed meals were to be delivered promptly to ensure maximum temperature retention and to preserve quality of food.</p> <p>Observation revealed a food cart was delivered to the dining room containing 17 resident trays at 12:03 PM on 12/09/15. Further observation revealed the last tray was not removed until 12:50 PM on 12/09/15 (a total of 47 minutes). The last food tray removed from the food cart was intercepted at 12:50 PM in order to obtain temperatures of the food. Two surveyors and the Dietary Manager (DM) conducted a palatability test of the food. Food temperatures were as follows: meat - 95 degrees Fahrenheit, and peas - 92 degrees Fahrenheit. All of the hot foods tasted cold. A temperature of the nectar-thick dairy drink was 53 degrees Fahrenheit, and the drink tasted cool.</p> <p>Interview with the DM at 12:52 PM on 12/09/15</p>	F 364	<ol style="list-style-type: none"> 1) The one resident involved was served a new tray brought directly from the kitchen by a nursing assistant on 12/9/15. 2) The tray carts were observed to ensure that all trays were delivered in a timely manner on 12/15/15 and 1/5/16 by the administrator. 3) All nursing staff was in-serviced on assisting with meals, resident rights and infection control completed by 1/31/16 by the DON. The majority of the residents who require assistance with feeding were fed during the first meal service. This has been changed so that approximately 1/2 of those needing feeding assistance eat at each meal service 4) Dietary Manager/dietician will monitor meal service in total watching closely for prompt delivery times, proper temperatures and good food quality at least once per week for 4 weeks and monthly thereafter. Results will be reported to the QA committee. 5) 1/31/15 		

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F 364	Continued From page 20 revealed the food was not warm enough, and the milk was not cold enough. The DM stated 47 minutes was too long for the trays to sit before being served.	F 364			
F 371 SS=D	483.36(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 facility policy review, it was determined the facility failed to maintain the kitchen in a sanitary manner. Observations on 12/09/15 and 12/11/15 revealed the blade on the can opener had a buildup of red food debris. In addition, the top of the steamer contained an accumulation of dust and powdered drink mix. The findings include: 1. Review of the facility's sanitation/infection control policy dated August 2014 revealed the can opener was to be cleaned and sanitized after each use.	F 371	1) The can opener was cleaned and surfaces were cleaned on 12/9/15 by the cook. 2) All kitchen equipment was evaluated for cleanliness by the dietary manager on 12/16/15. No other concerns were noted. 3) All kitchen staff were instructed on 12/9/15 or upon their return to work by the dietary manager that all food contact surfaces should be cleaned after each meal and that other areas in the kitchen should be cleaned per the established cleaning schedule. The cleaning schedule has been reviewed by the dietary manager and is determined to be adequate. The dietary manager will check kitchen equipment at least weekly to make sure that it is clean and cleaned after each meal if used for that meal. The dietary manager will make sure that the cleaning schedule is followed. 4) The registered dietician will do monthly sanitation audits to assure that the kitchen is maintained in a sanitary manner and that the cleaning schedule has been followed. Findings		

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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 12/11/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 98 STATE ROAD 3444 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 371	Continued From page 21 Observation at 10:25 AM on 12/09/15 revealed the can opener blade contained a heavy buildup of dried red food debris. The red food debris covered the entire blade of the can opener. Interview with the Dietary Manager (DM) revealed the can opener should be cleaned every day. The DM stated the can opener blade did not look like it had been cleaned since the previous day. 2. Interview with the Dietary Manager revealed the facility was unable to locate a policy related to cleaning the steamer unit. Observation of the steamer unit at 2:20 PM on 12/11/15 revealed the top of the steamer was covered with an accumulation of dust. In addition, powdered drink mix had been spilled on top of the steamer. Interview with staff at 2:20 PM on 12/11/15 revealed powdered drink mix had been splashed on top of the steamer because it was located beside the sink where the drink mix was prepared. Staff stated the dust accumulated on top of the steamer because the staff person responsible for cleaning the steamer had not worked in over a week.	F 371	of audits will be reported during the QA committee meeting for review. 5)	1/9/15	
F 441 SS-D	483.85 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	F 441	1) Resident #7 was immediately served another sandwich from the kitchen by the nurse aid on 12/9/15.		

Jan. 22. 2016 2:18PM

No. 1490 P. 23

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE: 96 STATE ROAD 3444 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 441	Continued From page 22 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 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 STANDARD is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to maintain an effective infection control program to prevent the development and transmission of disease/infection for one (1) of thirteen (13)	F 441	2) All residents were monitored to ensure that each resident was delivered their tray and staff met the infection control program guidelines on 12/15/15 by the administrator. 3) Nursing staff were educated on the infection control policy and procedure, to include appropriate food handling by the DON on 12/18/15. The Administrator, DON, dietician or the dietary manager will observe meal service once per week to make sure that staff are using proper feeding techniques and training will be administered as needed. 4) The dietician will observe meal service at least once per month to assure that proper feeding/infection control techniques are followed. Findings will be reported during the QA meeting for review. 5)	1/9/15	

Jan. 22. 2016 2:19PM

No. 1490 P. 24

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 96 STATE ROAD 3444 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 441	<p>Continued From page 23</p> <p>sampled residents (Resident #7). During the dinner meal service on 12/09/15, State Registered Nurse Aide (SRNA) #6 touched Resident #7's meatball sandwich with her gloved hands after adjusting Resident #7's overbed table with the same gloved hands.</p> <p>The findings include:</p> <p>Review of the facility policy, "Standard Precautions," revised August 2007, revealed employees should not reuse gloves, and should remove gloves promptly after each use, and before touching non-contaminated items and environmental surfaces.</p> <p>Interview with the Nurso Consultant on 12/11/15 at 3:40 PM revealed the facility did not have a policy related to the handling of foods.</p> <p>During the dinner meal service on 12/09/15 at 6:05 PM, SRNA #6 touched Resident #7's meatball sandwich with her gloved hands after adjusting Resident #7's overbed table while wearing the same gloves and without washing/sanitizing her hands and replacing the gloves.</p> <p>Interview with SRNA #6 on 12/09/15 at 6:08 PM revealed the SRNA stated, "I should have changed gloves after adjusting the bedside table." Further interview with SRNA #6 revealed facility staff was trained monthly on infection control and handling of residents' food.</p> <p>Interview conducted on 12/11/15 at 2:15 PM with the Director of Nursing (DON) revealed the SRNA should have washed her hands before delivering the meal tray, and after touching the bedside</p>	F 441			

Jan. 22. 2016 2:19PM

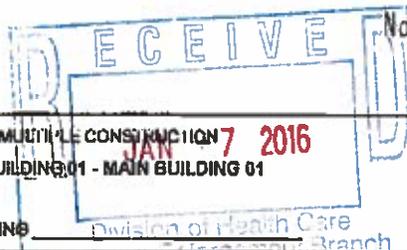
No. 1490 P. 25

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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 12/11/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 96 STATE ROAD 3444 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 441	Continued From page 24 table. Additional interview with the DON revealed she conducted random audits to monitor staff touching food with bare hands.	F 441			

Jan. 7. 2016 4:04PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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No. 1066

P. 1/6
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 12/10/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 96 STATE ROAD 3444 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	INITIAL COMMENTS BUILDING: 01 PLAN APPROVAL: 1989 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V (III) SMOKE COMPARTMENTS: 5 COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 12/10/15, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility to not be in compliance with NFPA 101 Life Safety Code, 2000 Edition. The census was 51 residents on the day of the survey. The facility has a capacity for 51 beds. Deficiencies were cited with the highest deficiency identified at "1" level.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	The egress maglock at the gate has been unlocked while submitting an application for a dual egress waiver. The gate will remain unlocked until the waiver is approved. Proper signage with the by-pass code will be reinstalled when the gate lock	

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

PhA. Bullock

TITLE

Adm

(X6) DATE

1-7-15

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.

Mar. 8. 2016 3:22PM

No. 2713 P. 1

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 88 STATE ROAD 3444 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 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors equipped with delayed egress had a readily visible sign in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect two (2) of five (5) smoke compartments, twenty-six (26) residents, staff, and visitors. The findings include: Observation on 12/10/15 at 2:17 PM, with the Maintenance Director revealed the Dining Room and Patient Lounge exits were equipped with delayed egress hardware. Both exits led to a grassy area surrounded by a locked gate also equipped with delayed egress hardware, but was missing the proper signage showing how to exit from the area. Interview with the Maintenance Director at the time of the observation revealed the facility did have the proper signage in place on the gate, but was not aware that it was missing during the survey. Further interview revealed the facility did not have a categorical waiver allowing for two delayed egress hardware equipped doors in the path of egress. The Administrator acknowledged the findings during exit. Reference: NFPA 101 (2000 Edition).	K 038	is put back in operation. Once waiver is granted and gate is in operation the maintenance manager will check for proper operation monthly. The delayed egress lock eliminated Returned to service when waiver arrives.	12/16/15

Jan. 7. 2016 4:05PM

No. 1066 P. 3/6

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 96 STATE ROAD 3444 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 038	<p>Continued From page 2</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbs. (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in</p>	K 038		

Jan. 7. 2016 4:05PM

No. 1066 P. 4/6

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 86 STATE ROAD 3444 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 038	Continued From page 3 letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which	K 038		

Jan. 7. 2016 4:05PM

No. 1066 P. 5/6

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN			STREET ADDRESS, CITY, STATE, ZIP CODE 98 STATE ROAD 3444 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 038	Continued From page 4 egress is to be made. Reference: NFPA 101 (2000 Edition) 7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.) Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required width of a stair or landing when the door is fully open.	K 038		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure illumination of exits was according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, twenty-six (26) residents, staff, and visitors.	K 045	The lights have been ordered and will be installed by a master electrician by January 31, 2016. This should permanently correct the deficiency. The maintenance department manager will check the bulbs monthly to make sure that they are operational.	12/31/15

Jan. 7. 2016 4:06PM

No. 1066 P. 6/6

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K 045	<p>Continued From page 5</p> <p>The findings include:</p> <p>Observation on 12/10/15 at 2:13 PM with the Maintenance Director revealed the exterior exits at the Dining Room and Pallent Lounge were not equipped with a two-bulb light fixture illuminating the exit egress. Interview with the Maintenance Director at the time of observation revealed he was not aware the light fixtures at the emergency exits needed to be equipped with two light bulbs.</p> <p>The Administrator acknowledged the findings during the exit conference.</p> <p>7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p>	K 045		